REQUEST FOR BID

STATE OF WISCONSIN
DEPARTMENT OF HEALTH & FAMILY SERVICES
DIVISION OF HEALTH CARE FINANCING

RFB #0423-DHCF-SM

HEALTH CARE QUALITY ASSURANCE AND UTILIZATION REVIEW
FOR THE WISCONSIN MEDICAID PROGRAM

BIDS MUST BE RECEIVED BY 2:00 PM FEBRUARY 11, 2004

LATE BIDS WILL BE REJECTED
FAXED BIDS WILL NOT BE ACCEPTED
THE STATE RESERVES RIGHT TO REJECT ANY AND ALL BIDS

WISCONSIN MEDICAID

VENDORNET INFORMATION FOR BIDDERS

http://vendornet.state.wi.us/vendornet/

INFORMATION ABOUT VENDORNET

Vendors may access VendorNet for inclusion on the bidders list for goods and services that the organization wants to sell to the state. A "subscription with email notification" guarantees the organization will receive an e-mail message each time a state agency, including any campus of the University of Wisconsin System, posts a request for bid or a request for proposal in their designated commodity/service area(s) with an estimated value over $25,000.

The annual fee for this service is waived. If questions exist about VendorNet, call the VendorNet Information Center at 1-800-482-7813 or, for Madison area organizations, call 264-7898 or 264-7897.

LEGAL NOTICE IN THE NEWSPAPER

Legal notice of this Request for Bid will be published in the official state newspaper, TheWisconsin State Journal on 11/20/04 and again on 11/27/04.

ONLINE POSTING OF THE RFB AND BIDDERS' CONFERENCE ANNOUNCEMENT

Further information online is available at http://www.dhfs.state.wi.us/rfp

DATES RELATED TO RFB PUBLICATION

Request for Bid Issued:..... 11/20/03
Letter of Intent to Bid Due:..... 12/12/03
Bidders' Conference: 12/23/03
Deadline for Receipt of Written Questions:..... 01/07/04
Answers to RFB Questions and Issuance of Addenda: 01/21/04
Technical Bid and Cost Bid Due: 02/11/04
Opening of Cost Bid: 03/10/04
Notification of Intent to Award Contract (estimated):..... 03/17/04
Contract Effective Date: 07/01/04

REQUEST FOR BID
RFB #0423-DHCF-SM

Wisconsin Department of Health and Family Services

WISCONSIN MEDICAID

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10.000 INTRODUCTION AND BACKGROUND INFORMATION

10.100 SOLICITATION FOR BIDS

The Wisconsin Department of Health and Family Services (DHFS) is soliciting bids from federally Centers for Medicare and Medicaid (CMS) designated External Quality Review Organizations (EQROs) to provide health care review processes relative to care provided to persons covered under the Wisconsin Medicaid program(s), hereafter known as Wisconsin Medicaid or Medicaid. Bids from non-qualified peer review organizations are not acceptable. The areas of review are:

- Managed Care Organizations (MCO) ambulatory care.
- Non-MCO, Fee for Service (FFS), inpatient hospital admissions and stays for medical, surgical, mental health (MH), and substance abuse (SA) treatment.
- FFS ambulatory care.
- Special Managed Care Organizations (SMCO's) care.

The Wisconsin DHFS has elected to solicit bids from only qualified peer review organizations due to the following reasons:

- This will enable the State to continue compliance with federal utilization review requirements identified in Section 42 CFR Part 456 Subpart C - Utilization Control: Hospitals and Subpart D-Utilization Control: Mental Hospitals. There are 139 Medicaid certified hospitals in Wisconsin.
- The State receives enhanced federal funding for contracting with a qualified peer review organization to perform medical and utilization review for the Wisconsin Medicaid program.
- Federal law requires that EQR activities be conducted only by "qualified" entities as defined in 42 CFR §438.354 "Qualifications of External Quality Review Organizations."

10.101 Procuring and Contracting Agency

This Request for Bid (RFB) is issued for the State of Wisconsin by the DHFS, which is the sole point of contact for the State of Wisconsin during the selection process.

The contract resulting from this RFB will be administered by the DHFS, Division of Health Care Financing (DHCF), Bureau of Health Care Program Integrity (BHCPI). The Contract Administrator will be the Director of the Bureau of Health Care Program Integrity, currently Alan S. White. The BHCPI Director ("Director") shall represent all of the Department's interests and rights under the contract.

With regard to the contract language found, Bidders may not place any conditions, reservations, limitations, or substitutions in their bid. The Bidder selected under this RFB may request non-substantive changes to the contract language, but the Department reserves the sole right to accept or reject any requested changes.

Bids submitted in response to this RFB shall become the exclusive property of the Department and may be retained, returned, used, reproduced, distributed, and/or destroyed by the Department at its sole discretion. For purposes of public record keeping, the Department will retain at least one copy of each bid.

10.102 Introduction and Background to the Medicaid Health Care Reviews

Medicaid is a federal/state program that pays health care providers to deliver medically necessary health care services to aged, blind or disabled individuals, members of families with dependent children, and certain other children and pregnant women. Wisconsin Medicaid operates pursuant to §. 49.43 - 49.499, Wisconsin Statutes, and Titles XIX and XXI of the Social Security Act.

Medicaid is the largest and most complex program in state government. The Wisconsin Medicaid "all fund" comprises about 16.33 percent of the Wisconsin "all fund" total. Wisconsin Medicaid is larger than any private insurer in the state.

The Division of Health Care Financing (DHCF) administers Wisconsin Medicaid funds and monitors contracts with 13 Managed Care Organizations (MCOs) in 68 counties to provide services to Medicaid eligible persons. DHCF also administers Wisconsin Medicaid funds and monitors contracts with Special Managed Care Organizations in Wisconsin.

MCOs cover all Wisconsin Medicaid services except prenatal care coordination, case management, and school-based services, which are covered on a FFS basis. MCOs may also choose not to cover dental or chiropractic services. (If dental and chiropractic services are not covered by the MCO, enrollees are covered on a Fee for Service [FFS] basis.)

SMCOs include Children Come First, Wraparound Milwaukee, and iCare in Dane and Milwaukee counties. These organizations provide health care to special populations such as children with severe emotional disturbance and the frail elderly.

10.103 Medicaid Health Care Reviews

Federal regulations require state Medicaid agencies to conduct on-going evaluations of the need for, the quality, and the timeliness of Medicaid services. According to 42 CFR sec. 456.3 the state "Medicaid agency must implement a statewide surveillance and utilization control program that:

- Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments;
- Assesses the quality of those services;
- Provides for the control of the utilization of all services provided under the plan;
- Provides for the control of the utilization of inpatient services . . ."

In addition, 42 CFR §438.204(d) requires that states have, as part of their Medicaid quality improvement strategy, "Arrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each MCO and PIHP contract."

Pursuant to Section 42 CFR sec. 456.2(b) the state Medicaid agency can either assume direct responsibility for meeting inpatient general hospital and mental hospital federal review requirements or the agency can contract with a qualified peer review organization. Wisconsin has elected to contract with a qualified peer review organization to assist in meeting the federal review requirements.

Federal regulations also require states that enroll Medicaid recipients in HMOs to contract with an accredited review body for the review of recipients' medical care to ensure that recipients are receiving good quality of care and services appropriate to meet their medical needs.

The health care reviews specified in this RFB are designed to identify and eliminate unreasonable, unnecessary, or inappropriate care provided to Wisconsin Medicaid recipients, and promote completeness, adequacy, and good quality of services for which payment may be made, in whole or in part, under Title 19 of the Social Security Act. Furthermore, this medical care review is intended to assure that in-hospital and non-hospital care provided is of good quality and medically necessary, is provided in the least costly setting appropriate to the patients' needs consistent with professionally recognized standards of medical care.

10.104 Non-HMO Inpatient Hospital Reviews

There are 126 general acute care hospitals and 13 specialty hospitals [Institutions for Mental Diseases (IMDs)], certified by the Wisconsin Medicaid as participating hospital providers.

Non-HMO inpatient hospital reviews include mental health (MH) and substance abuse (SA) inpatient reviews. The purpose of these reviews is to determine the medical necessity of Medicaid-covered MH and SA hospital admissions. Implicit in the finding of medical necessity is the concept that inpatient hospital care is medically necessary if outpatient treatment needed to assure the health and safety of the recipient or others is not available.

During the current contract year (July 1, 2004-June 30, 2005), the Contractor will complete the required retrospective non-HMO inpatient hospital medical chart review. Refer to **Part 3** of this RFB, Sections 70-90 for the description of the required review activities for the types and numbers of reviews.

10.105 HMO Quality Improvement Reviews

Pursuant to Section 1902(a)(23) USC, states may not restrict recipients' freedom to select health care providers. However, Section 1915 (b)(1) of the federal Social Security Act authorizes states, with federal approval, to require Medicaid recipients to enroll in an HMO, as a less costly method of providing health care than the traditional fee-for service providers. Under this federal waiver and approval to use HMOs, Medicaid recipients who are enrolled in an HMO are entitled to receive, as needed, all the Medicaid benefits available to persons who are not enrolled in an HMO. Wisconsin has had a waiver since 1984 to enroll Medicaid recipients in Department-contracted HMOs.

During the current contract year (July 1, 2004-June 30, 2005) the Contractor will complete retrospective HMO ambulatory services chart reviews. Refer to **Part 3**, Section 100.200 for quality of care review criteria and Appendix 20 for examples of the quality of care review instruments.

10.106 Fee-for-Service Quality Improvement Reviews

The FFS non-HMO review of ambulatory quality care is a similar process to the HMO quality improvement reviews. The purpose of the retrospective review is to assure that the ambulatory care provided to FFS recipients is complete, timely, medically necessary and consistent with generally accepted standards of care.

During the current contract year (July 1, 2004-June 30, 2005) the Contractor will complete retrospective FFS ambulatory services chart reviews. Refer to **Part 3**, Section 110 for the description of the required review activities and numbers of reviews.

10.107 Special Managed Care Organizations Quality Improvement Reviews

Populations of Medicaid recipients with special health problems and disabilities have demonstrated an increased utilization of health care resources. The DHCF has implemented programs designed to utilize care management and case management to help these recipients avoid institutionalization. The purpose of the review is to assure that the care provided to recipients enrolled in the special managed care programs is complete, timely, medically necessary, appropriate and consistent with generally accepted standards of care.

During the current contract year (July 1, 2004-June 30, 2005) the Contractor will complete reviews of the care and case management by these programs. Refer to **Part 3**, Section 120, and Appendix 23 for the description of the required review activities and numbers of reviews.

In addition, the Contractor is required to submit as part of its bid, a description of its plan to implement the federal external quality review protocols. Refer to Appendix 27 for a list of the protocols. Conduct of activities by the Contractor based on the protocols may be required under the contract, at the option of the DHCF. The full scope of work under the contract to be awarded subsequent to the RFB process shall include specific guidance to the EQRO Contractor based on the CMS EQRO Protocols incorporated by reference herein.

20.000 PROCUREMENT PROCESS

20.100 REQUEST FOR BID (RFB) ORGANIZATION

The RFB is organized into three (3) parts plus Appendices:

Part 1: PREFACE SECTION 10: Solicitation for Bids, Background of Wisconsin Medicaid Health Care Reviews (pages 10-1 through 10-4).

Part 2: GENERAL SPECIFICATIONS SECTIONS 20-60: Describes the Procurement Process (section 20); Preparing and submitting a bid (section 30); BID review and award method (section 40); Provisions and expectations relative to contractual content (section 50); Payment for contractor services (section 60). Provides bidders with the rules for the procurement, bid requirements and a description of how the bid will be reviewed by the state (pages 20-1 through 60-3).

Part 3: SCOPE OF CONTRACTOR ACTIVITIES SECTIONS 70-120: Describes the contractor scope of services; provides bidder with the specifications of the required reviews (pages 70-1 through 120-10).

Appendices: Consists of documents to support information contained within this RFB.

20.101 RFB Timetable

The following schedule is anticipated for this procurement. These dates are subject to change at the sole discretion of the Department. All time references are Central Time (CT).

RFB Issued: 11/20/03
Letter of Intent to Bid Due: 12/12/03
Bidders' Conference: 12/23/04
Deadline for Receipt of Written Questions: 01/07/04
Answers to RFB Questions and Issuance of Addenda: 01/21/04
Technical Bid and Cost Bid Due: 02/11/04
Opening of Cost Bid: 03/10/04
Notification of Intent to Award Contract (estimated): 03/17/04
Contract Effective Date: 07/01/04

20.102 Letter of Intent

Prospective bidders are requested to submit a Letter of Intent by December 12, 2004, to the Bureau of Health Care Program Integrity (BHCPI) Director at the address specified in Section 20.103 of this RFB.

The Letter of Intent shall clearly and completely identify the prospective bidder (e.g., firm or organization) and the full name, title, complete street address, office telephone number (direct line is preferred), e-mail address, and fax number of the prospective bidder's contact person. It shall also be clearly marked as Letter of Intent and cite the name of this project.

Failure to submit a timely and complete Letter of Intent will not preclude the submission of a bid, nor does submission of a timely and complete Letter of Intent require that the prospective bidder submit a bid.

However, only those prospective bidders submitting a timely and complete Letter of Intent will remain on the mailing list for:

a. Notice of changes (if any) to the procurement schedule specified in 20.101;

b. Questions and answers from Bidder's Conference;

c. RFB addenda or clarifications (if any); and

d. Other important information from the Department regarding this RFB.

This information will be sent by e-mail to the contact persons identified in the respective Letters of Intent.

20.103 Clarification and/or Revisions to the Specifications and Requirements

If additional information is necessary to assist in interpreting the specifications contained herein, prospective bidders may submit technical and contractual questions concerning this RFB **in writing** to:

Alan S. White, Director
Bureau of Health Care Program Integrity
Division of Health Care Financing
Post Office Box 309
Madison, Wisconsin 53701-0309
FAX: (608)-266-1096

- Written questions received at the Department after 01/07/04 will not be answered.

- Questions received before the deadline may be reviewed, consolidated, and paraphrased.

- Questions will be answered at the Bidders' Conference.

- **Non-written questions are prohibited**. Any oral responses, information, data, and/or advice (including telephonic responses, information, and/or advice, and any oral responses given during the Bidders Conference) received by a prospective bidder from the Department or Department staff shall not, in any manner whatsoever, be binding on the State of Wisconsin, unless followed-up and explicitly confirmed in writing by the BHCPI Director.

20.104 Bidders' Conference

A bidders' conference will be held from 2:00 p.m. to 4:00 p.m. on December 23, 2004, in Room 950B, One West Wilson Street, Madison, Wisconsin. The Department reserves the right to hold the conference in an alternate room at this building, and if so, will post the room number of the alternate room near the door to Room 950B unless there is sufficient time to notify prospective bidders by mail.

Written questions can be submitted up until January 7, 2004. Bidders are also encouraged to bring written questions to the Bidders' Conference. All Bidders' questions, concerns, or requests for additional information regarding the RFB, supporting documentation, or other matters related to the Medicaid program will be discussed at the Bidders Conference. To the extent possible, Department staff will provide immediate verbal responses to questions asked in the Bidders' Conference. However, such responses shall not be considered binding on the Department until reduced to writing. Where immediate responses are not possible, Department staff will research the issues and respond in writing. The Contract Administrator will prepare an official written response to all Bidder inquiries voiced at the Bidders Conference.

20.105 Addenda to RFB

The State reserves the right to modify, at its sole discretion, this RFB at any time prior to the bid due date by issuing written addenda. This includes but is not limited to revisions, additions, clarifications, and/or deletions. All written addenda to the RFB will become part of the final contract.

The Department will send all written addenda via certified or overnight mail to only prospective bidders which filed a timely and complete letter of intent to bid for this RFB to the Department.

20.106 Use of E-mail and FAX Machines

The Department may use e-mail and/or fax machines to transmit information (e.g., questions, RFB addenda) to prospective bidders. However, the Department will also

use the United States Postal Service or a commercial overnight delivery service to send originals.

Prospective bidders assume sole responsibility for ensuring that the Department actually receives (on a timely and complete basis) written questions, letters of intent, requests for copies of the RFB, and other inquires (whether transmitted by fax machine, the U.S. Postal Service, and/or a commercial delivery service, and/or delivered in person) from the prospective bidders.

Bidders may not submit technical or cost proposals by fax or modem. Bids submitted, in whole or in part, by fax, by modem, or on electronic media shall be rejected.

20.107 Restrictions on Contacts with State Personnel

From the date of release of this RFB until a determination is made and announced regarding the award of a contract as a result of this RFB, all contacts regarding this RFB with personnel in public office, employed by or contracted to the State of Wisconsin and associated with this RFB are restricted.

No prospective bidder (including any employee, agent, or subcontractor thereof) or its representative or agent shall approach personnel employed by or contracted to the State or any other agency participating in Title XIX regarding this RFB or this project without the prior express written permission of the Director of the Bureau of Health Care Program Integrity (BHCPI).

Violation of these conditions may, at the sole discretion of the BHCPI Director, be considered sufficient cause by the Department to reject a bid, irrespective of any other considerations.

20.108 Incurring Costs

The State of Wisconsin assumes no responsibility or liability for any costs incurred by bidders for developing and submitting bids or for participation in oral presentations.

20.200 DESIGNATION OF CONFIDENTIAL AND PROPRIETARY INFORMATION

The Wisconsin Open Records Law requires public disclosure of all sealed bids and related documents upon execution of the contract. Inspection is subject to the statutes and rules of the State of Wisconsin.

Prospective bidders shall complete Form DOA-3027 Designation of Confidential and Proprietary Information for items or materials the bidder wishes to keep confidential under the Wisconsin Open Records Law. This form must be completed and filed with each bidder's technical bid. This form (Form DOA-3027) is found in Appendix 1.

Prospective bidders shall also complete the Business Associate Form required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This form will

be modified and signed after acceptance of the cost bid. This form is found in Appendix 26.

Even if a bidder submits this form, however, the State will be required to make an independent determination whether any parts of the technical bid are confidential under applicable legal principles, in the event a request for such information is submitted under the Wisconsin Open Records Law.

20.201 RFB Cover Page

Bidder will provide contact information of key individuals within the Bidder's organization by completing the Vendor Information form (DOA-3477) located in Appendix 4. Finally, bidders will provide reference information by completing the Vendor Reference form (DOA-3478) located in Appendix 4A.

The forms described in 20.201 along with the HIPAA Business Associate Form are to be submitted as the cover pages to the Technical Bid.

20.202 Certification of Independent Price Determination

By submission of a bid the bidder certifies, and in the case of a joint bid, each party thereto certifies as to its own organization and in connection with this procurement that:

1. The prices proposed have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other bidder or with any other competitor;

2. Unless otherwise required by law, the prices quoted have not been knowingly disclosed by the bidder on a prior basis directly or indirectly to any other bidder or to any other competitor; and

3. No attempt has been made or will be made by the bidder to induce any other person or firm to submit or not to submit a bid for the purpose of restricting competition.

By signing the bid, each person(s) certifies that:

1. The person is the person in the bidder's organization responsible within that organization for the decision as to the prices being offered, and that they have not participated, and will not participate in any action contrary to the above; or

2. The person is <u>not</u> the person in the bidder's organization responsible within the organization for the decision as to the prices being offered but that the person(s) has been authorized in writing to act as agent for the persons responsible for such

decisions in certifying that such persons have not and will not participate in any action contrary to the above.

20.203 Withdrawal of Application

Bids may be withdrawn by written notice anytime prior to the opening of the Cost Bid. Bids may be withdrawn in person by the applicant or his/her authorized representative, providing that his/her identity is made known when he/she signs a receipt for the bid.

20.204 Contents of Bids

The contents of the Technical Bid and Cost Bid, as accepted by the State, will become part of any contract awarded as a result of this RFB to the extent they do not conflict with this contract or RFB. The State will have the right to use all ideas or adaptations of those ideas contained in any bid received in response to this RFB.

20.205 Prime Contractor

The Contractor will be responsible for the performance and shall supervise the review activities performed under this RFB. The Contractor shall have the duty and the authority to control and direct the performance of the contractual services. However, the Contractor's performance must meet with the approval of the Department and shall be subject to the Department's general right of inspection and supervision to secure satisfactory and timely completion.

If the Prime Contractor plans to use subcontractors, this should be clearly explained in the bid. However, the prime Contractor will be responsible for contract performance whether or not subcontractors are used.

If the prime Contractor does not locate its principal functions within the Madison, Wisconsin standard metropolitan statistical area, the bidder must include plans for facilitating communication between the Contractor's location and Department offices in Madison. The Contractor is required to meet with the Department on a semi-annual basis to discuss any contract issues and more frequently on 24-hour notice as determined by the Department.

20.206 Use of Subcontractors

In the event of a bid submitted jointly by more than one (1) organization, one (1) organization must be designated as the prime Contractor, and the prime Contractor will be solely responsible for assuring the performance of all aspects of the contract. All other participants shall be designated as subcontractors.

Contractor shall not, without prior written approval of the Department, subcontract for the performance of any of Contractor's contractual obligations. The provisions of the Contract shall apply with equal force and effect to all subcontractors engaged by the Contractor for review responsibilities and approved by the Department. Notwithstanding

approval by the Department, Contractor's use of a subcontractor shall not serve to terminate or in any way affect the legal responsibility of Contractor to the Department for the timely and satisfactory performance of the obligations contemplated by this Contract.

To assure Contractor's compliance with the Contract, the duly authorized agents or representatives of the Department shall at all times be accorded access to Contractor's premises or the premises of the Contractor's subcontractors. Refer to Section 50.612.

The Contractor is responsible to be in compliance to the HIPAA requirements relating to the conduct of business with subcontractors.

20.207 Bidder Information

The bidder is required to complete the vendor information form DOA 3477 and supply references using form DOA 3478. Also refer to section 30.104 for further information. Submit this information with the technical bid.

20.208 Conflict of Interest Affidavit

The Contractor and any subcontractor shall, as a prerequisite to approval by the Department, prepare and submit an affidavit that there does not exist a conflict of interest, within the meaning of 42 U.S.C. sec. 1320c-3(b) with respect to performance of any of the review activities which are the subject of the proposed subcontract.

20.209 Agreement to Accept and Abide by RFB and RFB Process

By submitting a bid in response to this RFB, each prospective bidder (including the bidder's proposed subcontractors and employees of the prospective bidder) agrees and consents, without reservation, substitution, or limitation, to each of the following:

1. Accept and abide by the bid submission requirements and rules and the procurement procedures, processes, and specifications identified in this RFB, including any RFB addenda and all appendices to this RFB.

2. Accept and consent to the Department's use of the bid review methods, process, criteria, and Bid Costs Forms (Appendix 6, including 6A and 6B) described in Section 40 of this RFB.

3. Accept and consent to the Department's sole, unrestricted right to reject any or all bids submitted in response to this RFB.

4. Accept the substantive, professional, legal, procedural, and technical propriety of the scope of work in the RFB.

5. If awarded a contract as the result of this RFB, accept the contractual language noted in this RFB and the standard terms and conditions and supplemental terms and conditions found in Appendices 3 and 3A of this RFB.

30.000 PREPARING AND SUBMITTING A BID

Guidelines for preparing and submitting the bids, elements to include in the description of the bidder's corporate capabilities, elements to include in the bidder's approach to contract implementation, and the requirements of the Technical and Cost Bids are set forth in this section.

Complete and concise information must be provided in response to each item in this RFB. Failure of a Bidder to respond to a specific requirement may be the basis for elimination from consideration during the State's review. Failure by a Bidder to meet the mandatory requirements set forth in section 30.000 - 30.502 may result in the rejection of the Bidder's bid.

30.001 Guidelines for Preparing the Bid

The following guidelines must be followed in preparing the bid:

- The entire bid must be typed one-sided on plain standard 8 1/2 x 11-inch paper. Do not include labeling on any page that identifies the Bidder. Brochures, artwork, thick paper, and visual or other presentation aids are not acceptable.
- The responses to all items must be single-spaced typed. Number each page.
- Bid must be organized and presented in the order and by the number assigned in the RFB.
- Begin the response to each of the separately numbered subsections 30.000 through 30.402 at the top of a new page.
- Place tabs between separately numbered sub-sections and use a three-ring binder to bind the technical bid.
- Staple each sub-section of the cost bid together separately through the upper left-hand corner. Do not use any other type of fastener.
- The bid must include a narrative response to each and every item listed, including a narrative demonstration of your financial resources and viability as requested.
- The outside of each part must be identified as the Technical or Cost Bid and labeled as the State of Wisconsin Medicaid Peer Review Organization Bid.
- Each Technical Bid and Cost Bid must clearly indicate that they are valid for a minimum of one year from the bid due date.

30.002 Submission of the Technical and Cost Bids

To be considered in the bid evaluation process, sealed bids must be mailed to:

Alan S. White, Director
Bureau of Health Care Program Integrity
Division of Health Care Financing
P.O. Box 309
Madison, WI 53701-0309

Or delivered to:

Alan S. White
1 West Wilson Street, Room 256
Madison, WI 53703

Bids must be prepared in two (2) components: Technical Bid and Cost Bid, prepared in accordance with the requirements stated in this RFB. The original and four (4) copies of the Technical Bid under sealed cover and the original and four (4) copies of the Cost Bid under separate cover must be received by the Department of Health and Family Services, at the address above, no later than 2:00 p.m., CT, on February 11, 2004.

Bids must be received in the designated **office** of the Department by the specified time. Bidders are cautioned that receipt of a bid by the United States Postal Service, State of Wisconsin mail system or a commercial carrier does not constitute receipt of a bid by the Department for purposes of this procurement. All bids that are received after 2PM on the closing date will not be reviewed and will be returned, unopened, to the bidder. **No exceptions will be allowed.**

The outside cover of the package containing the Technical Bid must be marked:

TECHNICAL BID
Medicaid Peer Review Organization Reviews
Name and Address of Bidder
Bid due: February 11, 2004
RFB #0423-DHCF-SM

The outside cover of the package containing the Cost Bid must be marked:

COST BID
Medicaid Peer Review Organization Reviews
Name and Address of Bidder
Bid due: February 11, 2004
RFB #0423-DHCF-SM

Submission of a bid shall constitute Bidder recognition and consent to adhere to the terms and conditions of this RFB and those in Form DOA-3054, Standard Terms and Conditions and in Form DOA-3681, Supplemental Standard Terms and Conditions. The form DOA-3054 is in Appendix 3. The form DOA-3681 is in Appendix 3A.

The Department reserves the right, at its sole discretion, to reject any or all bids. This RFB may or may not result in an award of Contract. The State reserves the right to cancel this RFB at any time and for any reason, and to reject all bids. Receipt of bids by the Department confers no rights upon the Bidder and does not obligate the State in any manner. Submission of a bid constitutes a Bidder's consent to the use of the review method set forth in Section 40.

30.003 Technical Bid Requirements

Each section within the Technical Bid must include all items listed in Sections 30.000 through 30.402 (including all subsections and following paragraphs within each subsection), for the section-by-section evaluation of bids.

The Technical Bid must include nine (9) separate sections (with tabs) presented in the following order:

1.	Transmittal Letter	(30.004)
2.	Cover Pages	(30.005)
3.	Table of Contents	(30.006)
4.	Executive Summary	(30.007)
5.	Assurances to Execute and Fulfill a Contract	(30.008)
6.	Corporate Capabilities	(30.100)
7.	Approach to Implementation	(30.200)
8.	Approach to Performance of Reviews	(30.300)
9.	Bidder Understanding	(30.400)

The technical bid must be presented in the exact order of bid requirements set forth in 30.002-30.402, to assure completeness of response by the bidder and to enhance understanding of the bidders response by the Department.

No reference to or inclusion of the Cost Bid may appear in any section of the Technical Bid.

30.004 Transmittal Letter

The Transmittal Letter must be on the official business letterhead of the Bidder proposing to become the prime Contractor and must be signed by an individual authorized to legally bind the Bidder. It must be part of the Technical Bid (with tab). The letter is to identify all material and enclosures being submitted in response to the RFB.

The Transmittal Letter must include the following statements that:

- The Bidder is the prime Contractor and is a corporation or other legal entity and a statement identifying any and all subcontractors.

- The bidder will assume sole responsibility for all Contractor responsibilities and work indicated in the RFB.

- No attempt has been made or will be made by the Bidder to induce any other person or firm to submit or not to submit a bid.

- The Bidder does not discriminate in employment practices. Refer to Appendix 3, Standard Terms and Conditions Form DOA-3054.

- The Technical Bid and Cost Bid are valid for one year from the bids due date.

- No cost or pricing information has been included in this letter or the Technical Bid.

- The person signing this bid is authorized to represent decisions on behalf of the Bidder's organization as to the prices quoted.

- The Bidder agrees to include, in their Medicaid Health Care Reviews, all the Wisconsin-specific features as contained in this RFB.

- The Bidder currently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of services under this contract, and shall not employ, any person having such interest.

- If Bidder is or would be associated with any parent, affiliated, or subsidiary organization, either under a formal or informal arrangement, in supplying any service or furnishing any supplies or equipment to the Bidder that would relate to performance under this contract, the Bidder is also required to submit with the bid written certification and authorization from the parent, affiliated, or subsidiary organization granting to the State, Federal Centers for Medicare and Medicaid, United States Department of Health and Human Services, and the Office of the Inspector General, and Comptroller General of the United States the right to examine and have access to any directly pertinent books, documents, papers, and records involving such transactions related to any aspect of maintaining the contract. Further, if, at any time after a bid is submitted, such an association arises, the Contractor will be required to obtain a similar certification and authorization from the parent, subsidiary or affiliate organization; failure to submit such certification and authorization will constitute grounds for termination of the contract at the option of the State.

- The Bidder agrees that any lost or reduced Federal Financial Participation incurred by the State resulting from unacceptable performance in a Contractor task or responsibility defined in the RFB, contract, or subsequent agreement will be offset by reductions or recoupments in payments.

- The Bidder certifies, through a notarized statement, that the Bidder, through its duly authorized representatives, declares that it has in no way entered into any arrangement or agreement with any other Bidder or with any public officer or Contractor of the State of Wisconsin in which the Bidder has offered or given or is to offer or give another Bidder or public officer any sum of money or anything of value; that the Bidder has not entered into any arrangement or agreement with any other Bidder or Bidders which could lessen or destroy free competition in awarding the contract sought by the attached bid; and that, unless otherwise required by law, the prices quoted shall not be knowingly disclosed by the Bidder prior to award, directly or indirectly, to any other Bidder or to any competitor.

If the bidder declares it's intention to use subcontractor(s), a statement from each subcontractor must be appended to the transmittal letter signed by an individual authorized to legally bind the subcontractor and stating:

- Name, location and address, telephone number and contact person.

- The specific activities to be performed by the subcontractor and the percentage of total work based upon Contractor price.

- The subcontractor's willingness to perform the work indicated.

- That the subcontractor does not discriminate in their employment practices. Refer to Appendix 3 for the Standard Terms and Conditions in requests for bid form DOA-3054.

If the bid deviates from the detailed specifications and requirements of this RFB, the Transmittal Letter must identify and explain these deviations. The State of Wisconsin reserves the right to reject any bid containing such deviations or to require modifications before acceptance.

30.005 Cover Pages

The bidder will identify confidential and/or proprietary information by completing DOA-3027 (Appendix 1). Bidders will also complete the Affidavit DOA–3070 (Appendix 2). Bidder will provide contact information of key individuals within the Bidder's organization by completing the Vendor Information form (DOA-3477) located in Appendix 4. Finally, bidders will provide reference information by completing the Vendor Reference form (DOA-3478) located in Appendix 4A.

The four forms described in 30.005 are to be submitted as the cover pages to the Technical Bid.

30.006 Table of Contents

The Technical Bid must contain a Table of Contents, which includes page numbers.

30.007 Executive Summary

The Executive Summary section will condense and highlight the contents of the Technical Bid in such a way as to provide a broad understanding of the entire bid.

The Executive Summary must include a clear and concise summary of the Bidder's corporate capabilities, project organization and staffing structure, approach to project implementation, approach to project operations, and understanding of the project. It shall also include a clear and concise summary of the Bidder's understanding of the project and the DHCF's needs.

30.008 Assurances to Execute and Fulfill Contract

Bidders must submit a signed and dated statement giving assurances that the Bidder will agree to execute and fulfill a contract according to the conditions, requirements, terms and reviews specified in this RFB.

30.100 CORPORATE CAPABILITIES

The Corporate Capabilities section must present the specific details regarding all appropriate, directly relevant experience, regarding Bidders previous and current health care review activities, including Medicare, Medicaid, and, if applicable, other pertinent health care review experience. This section is to be organized in the order as presented in 30.101-30.113.

30.101 Health Care Review Experience

The Health Care Review Experience section must present specific details of the Bidder's Medicaid, Medicare, and other health care review experience. This section is to be completed by the Bidder for all subcontractors (if any), and covers the time period of July 2001 through June 2003. The required details are:

1. Customer name for all health care review contracts (CMS, Medicaid, and / or other) including contract start and end dates.

2. Detailed description of the utilization and quality of care reviews performed per contract, including specific types of review (e.g., pre-admission, retrospective; inpatient, ambulatory) and number of health care reviews performed for each customer.

3. Submit bidder's pre-admission health care review tools used by nurse reviewers for screening mental health/substance abuse, medical and surgical pre-admission review cases. Submit a narrative of the pre-admission review process.

4. Submit a list which identifies types (e.g., ambulatory Well Children exam, Prenatal exam/visit, Inpatient Psychiatric Criteria for children) of criteria that would be used by nurse reviewers to initially screen medical records of inpatient and ambulatory care. Submit three examples of both inpatient and ambulatory criteria used by nurse reviewers.

5. Describe in detail the steps taken and individuals involved in developing, evaluating and revising the medical record screening criteria used by your nurse reviewers. Indicate the last time your inpatient and ambulatory criteria was revised and what prompted the update.

6. Describe all provider relations activities performed per contract (i.e., workshops, seminars, provider group meetings or conferences). Include information regarding topics presented, background and types of speakers, type of audience. Indicate if provider relation activities were provided solely by Bidder or in conjunction with other organizations or groups.

7. Describe in detail the health care review data collection and reporting performed for each customer. List the types of reports provided to each customer. Provide examples of three reports.

8. List of all lawsuits within the last five (5) years related to the bidder's health care reviews or contracts including names of all parties, nature of the lawsuit, status or final disposition.

30.102 Business Information

The Bidder is to include a description of the Bidder's organization and each subcontractor's firm (if any). This discussion will describe the business structure, organization's specific background in health care review services and corporate resources. Details will include:

1. Date established

2. Type of ownership (public company, partnership, subsidiary, etc.)

3. Total number of employees currently employed

4. Profit or non-profit status

5. Number of (FTE) personnel assigned to professional, analytical services, computer programming systems development, and project operations for each of the following:

a. Medicare health care reviews;

b. Medicaid health care reviews;

c. Other contracted health care reviews (commercial insurance, private business);

d. Other review activities not mentioned above;

e. Health care data collection systems, including data analysis, data integrity, data and process flow, data verification and validation, and data dictionaries;

f. Design, development, programming, testing, implementation, installation operation, flexibility, and maintenance of Bidder's health care data system for contracted health care industry clients; and

g. Computer resources and the extent to which they are dedicated to each contract.

30.103 Financial Statements

The Bidder and each subcontractor (if any) shall submit independently audited financial statements for the financially responsible entity for the last three (3) completed fiscal years. If the Bidder is a subsidiary, the parent company must be identified, and audited financial statements from the parent company must be submitted. Statements must include:

1. Balance sheets

2. Statements of income

3. Statements of change in financial position

4. Notes to financial statements

5. Auditors' reports and statements

The Department reserves the right to request and require any additional information to assure itself of a Bidder's financial status and stability.

30.104 Bidder References

Bidder must provide complete copies of CMS Peer Review Organization Performance Evaluations identifying performance deficiencies for the last three (3) years including

materials relating to plans of correction and documentation that the deficiency has been corrected.

For contracts identified in response to subsection 30.101, Bidders must include a list of references. The Department will check references at its option. References may be contacted to determine quality of work performed, timeliness and personnel assigned to project. Each reference must include the customer's name, address and current telephone number of the customer's responsible project administrator or senior official of the customer who is familiar with the Bidder's performance and who may be contacted by the Department during the review process. The Department reserves the right to contact officials of the customer other than those indicated by the Bidder.

30.105 Corporate Organization and Staffing

In this subsection, the Bidder shall present the personnel qualifications and staffing approach for successful performance in the implementation and operation of the Medicaid Health Care Reviews. The subsection will include:

1. Corporate and project level organization charts

2. Staffing level plans for each major activity of the contract

3. Key personnel qualifications and resumes

4. Back-up personnel qualifications and resumes

30.106 Organization Charts

The corporate organization chart must display the firm's overall structure and the organizational placement of the Medicaid Health Care Review contract including all major divisions of the firm and all positions which would impact the future contract. All key personnel, as defined in subsection 30.107, who will be assigned to this project must be shown on the organization charts, and their specific responsibilities throughout the contract period must be included.

30.107 Key Personnel

The following positions, or their equivalents in the Bidder's Bid organization, are minimally considered key personnel:

1. Review Director

2. Review Manager and staff reporting to manager

3. Program Planning and Development Manager and staff reporting to manager

4. Training and Quality Control Manager and staff reporting to manager

5. Information System/Data Processing Manager and staff reporting to manager

Each key person shall be identified by full name and specific responsibilities under this project shall be clearly and precisely detailed. Current assignments and the impact of reassignment in this effort must be presented.

Notwithstanding the Bidder's key personnel and staffing plans, the Contractor shall devote such full and part-time experienced personnel and positions (including clerical and support personnel, and personnel of subcontractors) to the performance of responsibilities under the contract as are necessary (throughout the contract term) to:

1. Satisfactorily perform the scope of work consistent with the highest professional standards.

2. Provide systems, services, deliverables, and work products on a complete and timely basis.

3. Meet contract requirements, objectives, and standards.

4. Meet the terms and conditions of the contract.

The Bidder's technical bid shall specify how this requirement will be met during the contract term. This responsibility of the Contractor includes ensuring, at all times throughout the contract term, that an adequate range and supply of specialized and directly relevant managerial, professional, and technical skills are available to the project.

30.108 Personnel Resumes

A detailed resume shall be provided for each key person identified by the Bidder. The resumes shall include:

1. Experience with State and/or Federal health care review systems
2. Experience directly relevant to the Bid responsibilities
3. Percent time committed to this project
4. Percent time committed to other projects/contracts
5. Key persons physical location during this project
6. Relevant education and training

30.109 Staffing Plan for RN and Physician Reviewers

This section of the bid must describe the Bidder's staffing plan to carry out effectively the review specifications and meet the requirements of the contract for the entire time the contract remains in effect. This section will include the following components:

1. RN Reviewer Staffing Plan

2. Physician Reviewer Staffing Plan

3. Physician Committee Staffing Plan

4. Allocation of Additional Personnel to meet RN/Physician Staffing Plan requirements

30.110 RN Reviewer Staffing Plan

The Bidder must submit a staffing plan for the first-year performance of the medical health care reviews specified in **Part 3** in Sections 80 through 120 of this RFB. The reviews are:

- Admission Reviews
- Delayed Admission Reviews
- Retrospective Reviews
- Division of Health Care Financing Referral Reviews
- Mental Health Substance Abuse Service Reviews
- Certificate of Need Non-Emergency Admission Reviews
- MCO Focused Provider Reviews
- MCO Performance Improvement Projects Reviews
- MCO Medical Record Quality of Care Reviews
- MCO Data Validity Audit
- FFS Retrospective Reviews
- FFS Focused Provider Reviews
- FFS Chronic Conditions Review
- FFS Targeted Physician Reviews
- FFS Random Sample Reviews
- SMCO On-site Reviews

- SMCO Performance Improvement Reviews

The staffing plan must specify the RN reviewer staff composition for each of the review areas by job classification and must reflect resource commitments (FTE) to fully support continuous review activity. The standards for each position must be described and will form the basis for State evaluation and approval of all future staff members in these areas. By presenting the qualification standards, the Bidder commits to using the standards as the minimum criteria for filling the positions. At a minimum the Bidder shall submit the following:

1. The number (FTE) of RN reviewers who would perform Bidder's various contracted health care reviews during the initial contract period broken down according to the review areas identified above.

2. A description of the clinical experience qualification standards for each RN reviewer who would be performing telephonic and/or retrospective medical record reviews described in this bid.

3. The number of RNs by clinical expertise who will be performing the health care reviews by review area described in this bid.

4. An identification of the number of (FTE) RN reviewers currently employed by Bidder who would be performing reviews described in this bid.

5. A description of the RN reviewer performance standards for each review area described in this bid. To include minimum number and type of retrospective medical record reviews completed/day/RN.

6. The extent to which each RN reviewer position will be dedicated to perform Medicaid reviews including the type and number of other reviews each RN reviewer is expected to perform under other contracts.

7. A detailed plan to assure RN reviewers will uniformly apply chart review criteria.

30.111 Physician Reviewer Staffing Plan

The Bidder must submit a physician reviewer staffing plan for the first contract period. At a minimum the Bidder shall submit the following:

1. Documentation demonstrating that the Bidder is currently composed of at least 20 percent of the licensed doctors of medicine and osteopathy currently practicing medicine or surgery in Wisconsin;

- or -

2. Bidder's detailed plan to obtain written agreements with at least 20 percent of the licensed doctors of medicine and osteopathy currently practicing medicine or surgery in Wisconsin to perform all of the physician peer review functions described in this bid prior to the contract effective date;

- and include -

3. Bidder's plan to assure adequate physician peer review for the first-year performance of the Non-HMO reviews including mental health and substance abuse reviews, and HMO and FFS medical care quality assurance reviews areas specified in this bid including resources to perform review of cases referred by RN reviewers. The plan must also include the number of physicians and amount of time that will be available by specialty and sub-specialty to perform reviews.

4. A description of the Bidder's plan for their physician staff to establish and revise review criteria as needed for this contract. This plan includes a description of the Bidder's approach to systematically review existing criteria in order to identify review areas in need of revision, the process to make revisions or establish new criteria, with the review and approval by Medicaid of the changes in review criteria, and criteria implementation.

5. Detailed plan to assure physician reviewers will consistently apply the same quality of care severity level to like quality of care failures identified through the medical record review process.

6. Proposed approach to assure the following review related administrative functions are provided during the contract year:

    a. Systematically review existing review criteria with bidder's internal physician committees, the Department, Medicaid HMO medical directors and practicing Medicaid certified physicians. Update existing review criteria as needed or as requested by the Department. All changes to existing criteria must be approved by the Department and disseminated to Medicaid providers prior to retrospective review.

    b. Per the Department's request develop new utilization and quality of care criteria.

    c. Practitioners understanding and compliance with current criteria.

30.112 Other Review Personnel including Consultants

Contractor review personnel shall include personnel who have a thorough understanding of epidemiology and statistical methods for the measurement of health status indicators in defined populations, including:

1. Scope and methodology of data collection.

2. Interpretation of data.

3. Understanding of the social and economic factors that affect data interpretation.

Because the activities to be undertaken by the Contractor include designing, assessing and implementing performance improvement quality of care studies, the Contractor shall have state of art expertise in research methods and statistical analytical methods sufficient to undertake these activities and to instruct Medicaid HMOs, as necessary, how and where to undertake such studies.

30.113 Back-up Personnel Plan

This subsection must include a discussion of the Bidder's contingency plan for allocation of additional personnel resources to the contract in the event of a missed milestone or inability to meet any performance standard. A discussion of the Bidder's contingency plan for replacement of personnel in the event of loss of key personnel must also be included. The Bidder must address situations of replacement/addition of a management person with specific qualifications and of replacement of several technical or other (non-key) personnel. Time frames necessary for replacements, the Bidder's capabilities to provide replacements/additions with comparable experience, and the method of bringing replacements/additions up-to-date regarding the Wisconsin requirements must be emphasized.

30.200 APPROACH TO IMPLEMENTATION

The Bidder's Approach to Implementation must explain in precise detail the following three (3) components of its implementation strategy.

30.201 Take Over Approach

The Bidder shall address their take over approach of the Contractor responsibilities specified in this RFB and the Bidder's approach to performing these responsibilities.

This component addresses the Bidder's approach to acquiring first hand familiarity with the current Medicaid health care review process, testing procedures during implementation and start up of operations.

30.202 Implementation Workplan

A detailed implementation workplan and task schedule is required. All tasks must be itemized into subtasks, activities, with timeframes for completion approved by the Department. This component must include the following:

1. A breakdown of all tasks and subtasks for the Implementation Phase, identifying major objectives and milestones for accomplishment plus points of review and authorization by the Medicaid contract monitor.

2. Calendar-based task schedules of the Implementation Phase showing estimated Department and Contractor person-weeks of effort by labor category for each task and subtask, both separately and totaled for each task. This includes a description of the Contractor's strategies used to assure compliance with Department delivery/reporting deadlines and schedules.

3. Chart showing start and end dates for all tasks and subtasks and the relationship between tasks and subtasks.

4. A schedule for submission and possible revision of all deliverables and their review by Department staff; this schedule must allow for revision and correction of review document materials not meeting Department approval.

5. In addition to the Bid work plan and schedule, the Implementation Phase materials must include a discussion of:

    a. Bidder's geographic location for the takeover of the required health care reviews and testing.

    b. Extent of RN staff training anticipated before full operations.

    c. Implementation activities, such as transfer of files and archival records, communications to Medicaid providers, computer programming, and other preparations for start of review operations.

    d. Report deliverables, including content, format, delivery and review schedule, and obtaining Department approvals.

    e. Any assumptions or constraints, including assumptions regarding resources identified in the work plan.

    f. Bidder's plans to discuss administrative and review procedures with Department staff.

30.203 Approach to Contract Management

In this section, the Bidder must discuss their approach to contract management. This approach must address:

1. Project management tools, including whether they are automated or manual.

2. Approach to project status reporting, including examples of types of reports.

3. Communications with Department staff (e.g., contract meetings, policy development, etc.).

4. Internal quality control procedures for deliverables.

5. Overall review process problems; (i.e., unanticipated project delays and missed deadlines).

6. Requests by the Department to revise deliverables (e.g., review criteria and/or process and/or reports).

30.300 APPROACH TO PERFORMANCE OF REVIEWS

This section of the bid will describe in detail the Bidder's approach to performing the responsibilities stated in **Part 3.**

30.301 Approach to the Performance of Review Tasks

The Bidder must describe its approach to the performance of the health care review responsibilities, specified in **Part 3,** including but not limited to:

1. A detailed work plan listing major objectives and identifying all tasks and subtasks required in performing the reviews and the timeframes for the accomplishment of each task.

2. A description of the final products that will be provided to the Department and/or providers, including managed care organizations, in terms of reports, trend analysis recommendations, notification of revisions to review process/criteria.

30.302 Computer Resources

This section must describe in detail the computer resources which will be used to meet contract requirements and the extent these resources are used to perform work required under other contracts, including:

1. Data processing equipment.

2. Location of data processing equipment.

3. Software capability.

4. Backup processing capabilities.

5. Processing of data from Department's fiscal agent.

6. Data processing, storage and transmission security provisions.

30.303 Review Support Activity

The Review Support Activity section must present the details of how review support activities such as maintaining records on reviews, tracking reviews through the review process, preparation of notice of findings, preparation of management reports, etc. will be performed.

30.304 Commitment to Performance Standards

In this section, the Bidder must define and quantify the performance standards it will uphold during the contract, as well as how it will monitor and assure compliance with performance standards specified by the Department. The Bidder must discuss how it will meet the defined performance standards. In addition, the Bidder shall cover the approach to meeting general performance standards, such as:

1. Full cooperative and responsive communications with Department staff.

2. Contract performance monitoring tools, such as:

    a. Operational controls on reviews, findings and production of report.

    b. Timeliness of review activity.

30.305 Overall Bid Strength

In this section, the Bidder will demonstrate that its approach will be the most beneficial option to the State. This section shall include an overall assessment of the strengths, commitments, and risks associated with the Bidder's bid. This section must include a discussion of anticipated problem areas, the approach to preventing or managing them, and their impact on State operations. This discussion will cover anticipated problems in all phases of the contract, including any preliminary testing during implementation of Medicaid DRG Grouper, MCO encounter data, FFS claim data, review operations, and Data processing operations. Specific items to be addressed include actions the Bidder will take in the event of the following:

1. Loss of 30 percent or more of bidder's review staff.

2. Loss of 30 percent or more of key review personnel.

3. Inadequate product delivery time.

4. Failure to meet other contract specification.

30.400 BIDDER UNDERSTANDING

30.401 Understanding of the Medicaid Health Care Review Process

To demonstrate understanding of the Medicaid health care reviews process, the Bidder must demonstrate that it has sufficient knowledge of the existing system to accomplish the takeover. In other words the Bidder must discuss the technical considerations of the takeover, the mechanisms which must be developed to support the existing reviews process, and its approach to performance issues.

30.500 COST BID REQUIREMENTS

The Bidder must provide a detailed Cost Bid. The Cost Bid is to be completed using the instructions and the required forms contained in Appendices 6, 6A, and 6B. The forms provide the means by which a Bidder must supply all costs. Failure to provide any requested information or deviation from the prescribed response format may constitute grounds for disqualification. There shall be no mention of the specific contents contained in the Cost Bid in any other document. The Contractor's proposal shall exclude reimbursement to the Contractor for hospital and HMO photocopying of medical records.

The Cost Bid is to be considered binding upon the Contractor for one (1) year after the date of submittal and throughout the term of the contract if awarded. <u>This statement must be included in the Cost Bid</u>.

30.501 Medicaid Health Care Review Bid Costs (Appendix 6A)

The Bidder must prepare and submit a completed Medicaid Health Care Review Bid Costs Form and a narrative according to the instructions. These costs shall be for the first year of operations and include implementation costs.

30.502 Review Time and Cost Report (Appendix 6B)

The Bid price amount is the sum of the costs for the reviews. The Bidder must prepare and submit a Review Time and Cost Report. The price per review category will be for reviews completed to final status as determined by the Department. The price per review is to include all costs for the Contractor. No bid cost shall be separate from the price per review. The Bidder must submit a firm, fixed price amount for all services. A legally authorized representative of the Bidder must sign and date each form. In addition:

1. The Bidder must describe the type of accounting system (e.g., accrual, cash accounting) which will be used to keep track of revenues and expenditures.

2. The Bidder must agree that all accounting procedures, policies, and records shall be completely open to state and federal audit at any time during the contract period and for five (5) years thereafter.

3. Results of the review must be available, on request, to the Secretary, the Office of the Inspector General (OIG), and the General Accounting Office (GAO).

40.000 BID REVIEW AND AWARD METHOD

The Wisconsin Medicaid Peer Review Organization contract shall be awarded to the responsible Bidder with the lowest cost bid, who meets all of the technical, quality, and reporting requirements specified in this RFB document including the appendices. Each technical bid will be reviewed to determine each Bidder's ability to successfully meet the requirements specified in this Request for Bid on the basis of pass or fail.

40.100 BID REVIEW PROCESS

This Bid will be reviewed using a two-phase process, i.e., technical responsiveness and cost comparison. Three (3) DHCF staff will review all bid responses. Any required item that is scored "present" by one reviewer and "not present" by the other reviewers will be reviewed by the three reviewers with an additional person present for a final determination based on the reviewers' consensus. Refer to Appendix 25 for the Technical Bid and Cost Bid Review Criteria Checklist.

40.101 Determination of Technical Bid Responsiveness

The State of Wisconsin Department of Health and Family Services will conduct a comprehensive, fair, and impartial review of the bids received in response to the Request for Bid. The determination of whether a Bidder's response conforms to the conditions and specifications of this RFB is the sole responsibility of the Department. The Department's determination of responsible Bidders will be conducted in two (2) steps:

- Step 1: An initial review by the Department of the Bidders' Technical responses for completeness, accuracy, and adequacy of information provided by the Bidders.

  The purpose of this step is to determine whether each Bid is complete and sufficiently responsive to the RFB. All Bidders' statements of Bidder's qualifications in response to this Bid document will be reviewed by the Department to determine whether all of the requirements of this Bid document are properly addressed. Bids will be reviewed to determine if they comply with the instructions to bidders listed in Section 30. Failure to comply with the instructions or to respond with complete and accurate information may cause a bid to be deemed non-responsive, except in those cases where the Department exercises its right to waive minor irregularities and request compliance from the Bidder. The Department may seek written clarification of responses received from Bidders whose Technical Bid document does not clearly provide all of the information required.

Any bid which is found incomplete or in which there are significant inconsistencies or inaccuracies may be rejected by the Department. The Department reserves the right to reject any and all bids.

- Step 2: Department's Review of the Statements of Bidder's Qualifications and Reference Checks.

  Determination as to whether or not a Bidder qualifies will be made by the Department of Health and Family Services. Reference checks will be conducted as part of this step. Information obtained in the reference checks that indicate the Bidder has experienced difficulties meeting the requirements and specifications of similar contracts may cause the Department to declare a bidder not qualified. Reference checks will not be limited to references cited in the bid.

  The determination of whether a Bidder's response conforms to the conditions and specification of this Bid Document is the sole responsibility of the Department. Those Bidders whose Statements of Bidder's Qualifications do not conform to all of the conditions and specifications of this Bid Document will be disqualified and their Statements of Costs will not be opened.

40.102 Review of Statement of Cost

The Department's determination of the lowest qualified responsible bid will be conducted in two (2) steps:

- Step 1: Opening of Statements of Cost.

  The Statements of Cost of qualified Bidders will be opened on March 10, 2004, at 2:00 p.m. CST in Room 350 of the State of Wisconsin, Wilson Street Office Building located at 1 West Wilson Street in Madison Wisconsin.

  Only those Bidders whose Statements of Qualifications conform to all of the conditions and specifications of this Bid document will have their Statement of Costs opened. The opening of the Statements of Cost are public actions and are open to attendance by interested Bidders and the public.

  The Department's purchasing agent will read the names of the Bidders found qualified, open the Statements of Cost of the qualified Bidders and orally report the total price of the bid which is located in the Cost Totals Column (Column 13) on the Review Time and Cost Report Form (Appendix 6B). Only reading of the names of qualified bidders and the price of the bid is required at a public opening of the Statement of Cost.

  No activity on the part of the Bidders at an opening of a bid, other than attendance and note taking, is permitted. Any attempt to qualify or change a bid by any Bidder in attendance may result in the rejection of that Bidder's bid.

- Step 2: Audit by the Department of the Statements of Costs for accuracy and mathematical errors.

  The next step in the review process will consist of an audit verification of the qualified Bidders' Statements of Costs. An incomplete or inaccurate Statement of Costs will result in Bidder disqualification.

40.200 TECHNICAL REVIEW

All bids submitted in response to this RFB will be reviewed by the State of Wisconsin, Department of Health and Family Services who will make the final selection of the Contractor. Bids will be reviewed according to criteria falling within the following categories.

40.201 Mandatory Requirement Criteria (Present – Not Present)

1.	Transmittal Letter	(Section 30.004)
2.	Cover Pages	(Section 30.005)
3.	Table of Contents	(Section 30.006)
4.	Executive Summary	(Section 30.007)
5.	Assurances to Execute and Fulfill a Contract	(Section 30.008)
6.	Corporate Capabilities	(Section 30.100)
7.	Approach to Implementation	(Section 30.200)
8.	Approach to Performance of Reviews	(Section 30.300)
9.	Bidder Understanding	(Section 30.400)

40.202 Review Criteria for Technical Bids (Present – Not Present)

The Department will apply the requirements set forth in Part 2, Section 30 to review the technical bids. These requirements are detailed in Sections 30.003 through 30.402.

40.300 STATEMENT OF COST RANKING

All bids with an accurate Statement of Costs verified by audit will be ranked with the lowest cost proposal as number one; the next lowest bid as number two, etc.

40.400 METHOD OF AWARD

The bidder agrees to the selection process when the bidder submits the Technical and Cost Bids.

40.401 Procedure in the event that a contract cannot be concluded successfully

The Department reserves the right to reject any and all bids and to negotiate the terms of the contract, including the award amount, with the selected Bidder prior to entering into a contract. If contract negotiations cannot be concluded successfully with the

lowest scoring Bidder, the State may negotiate a contract with the Bidder with the next lowest scoring bidder.

40.402 Notice of Intent to Award Contract

All bidders who respond to this RFB will be notified in writing of the Department's intent to award the contract as a result of this RFB. After notification of the intent to award is made on March 17, 2004, and under the supervision of Department staff, copies of the bids will be available for public inspection from 8:00 a.m. to 4:00 p.m. at the receiving office. Bidders may schedule reviews with Alan White at (608) 266-7436.

40.403 Appeals Process

Notices of intent to protest and protests must be made in writing. Protestors Shall make their protests as specific as possible and identify statutes and Wisconsin Administrative Code provisions that are alleged to have been violated.

The written notice of intent to protest the intent to award a contract must be filed with Helene Nelson, Secretary, Wisconsin Department of Health and Family Services, Post Office Box 7850, Madison, Wisconsin, 53701, and received in her office no later than five (5) working days after the notice of intent to award is issued.

The written protest must be received in his office no later than ten (10) working days after the notice of intent to award is issued.

The decision of the Secretary of the Department of Health and Family Services may be appealed to the Secretary of the Department of Administration within five (5) working days of issuance, with a copy of such appeal filed with the procuring agency. The appeal must allege a violation of a statute or a provision of the Wisconsin Administrative Code.

40.500 ACCEPTANCE OF BID CONTENT

The contents of the bid of the successful Bidder will become contractual obligations if procurement action ensues, to the extent the contents of the Bid are consistent with the terms of the contract. Failure of the successful Bidder to accept these obligations in a contractual agreement may result in the cancellation of the award.

50.000 PREFACE

State and Federal laws mandate the inclusion of specific substantive provisions in Department contracts that involve expenditure of Medicaid monies. The following reflects those provisions as well as other expectations of the Department relative to contractual content. In addition to the provisions that appear below, the final Contract will include provisions tailored to reflect the specifics of the successful bid. The final Contract will incorporate by reference the provisions of the RFB and successful bid. The Contract controls over the RFB which controls over the Bid.

50.001 Standard Contract Clauses

All services under this Contract shall be performed in accordance with the applicable Federal and State laws and regulations in effect at the time of performance, and this Contract shall be subject to all such laws and regulations.

50.002 Executed Contract to Constitute Entire Agreement

In the event of contract award, the contents of this RFB (including all attachments), RFB addenda and revisions, and the Technical Bid of the successful Bidder, and additional terms agreed to, in writing, by the Department of Health and Family Services and the Contractor shall become part of the Contract. Failure of the successful Bidder to accept these as a contractual agreement may result in the cancellation of award.

The Contract will constitute the entire agreement with respect to the subject matter hereof and there are no representations, understandings or agreements relative hereto which are not fully expressed herein. No change, waiver or discharge hereof shall be valid unless in writing and executed by both parties.

50.100 GENERAL CONTRACTOR DUTIES

50.101 General Contractual Responsibilities of Contractor

1. Notify the Contract Administrator in writing of any changes in the person or persons authorized to sign amendments to the Contract and receive notices under the Contract on behalf of Contractor.

2. Effect and maintain liaison and fully cooperate with designated Department staff with respect to the direction and performance of Contractor's contractual responsibilities.

3. Assume complete financial responsibility and liability for payment to creditors for costs incurred by Contractor in the performance of contractual obligations.

4. Immediately upon discovery of any problem which may jeopardize the successful or timely completion of its obligations, notify the Contract Administrator in writing of the problem, including in such notice Contractor's recommendation for expeditious resolution of the problem.

5. Refer to the Contract Administrator any suspected fraudulent or abusive practices Contractor encounters in the performance of its contractual activities. Produce, on a timely basis, reports, print-outs, and other documentation reflecting information or data possessed by the Contractor which is needed to investigate or document suspected instances of Medicaid fraud or abuse.

50.200 CONTRACT ACTIVITY

50.201 Subcontracting

Refer to Section 20.206 and to Section 50.612.

50.202 Contract Modification

Except where mandated by a change in State or Federal law, any modification to or amendment of the original Contract requires the mutual written consent of the parties.

50.203 Renegotiations

Renegotiations of the Contract may occur:

In the event the laws of the State of Wisconsin or of the United States are amended or judicially interpreted as to render unfeasible the fulfillment of the Contract on the part of either party, or if any State or Federal statute or implementing regulation promulgated pursuant thereto, or judicial interpretation thereof, should make it mandatory that the Contractor furnish a category or amount of benefits or services in excess of those contemplated or considered in establishing the charges herein, or

In order for the Contract to be in conformity with State or Federal law.

50.300 TERMINATION OF THE CONTRACT

The Contract between the parties may be terminated, in whole or in part, only as follows:

By mutual written agreement of the parties; or

By the Department for cause, upon a failure of Contractor to comply with any of the terms or conditions of this Contract, provided that the Department shall give

Contractor written notice specifying Contractor's breach. In the event that thirty (30) days after the receipt by Contractor of such notice, Contractor shall not have remedied said breach or, for a breach which cannot reasonably be corrected in thirty (30) days, commenced in good faith to correct said breach and thereafter proceeded diligently to complete such correction, the Department may, by giving written notice to Contractor, terminate the Contract as of the date specified in the notice.

Termination for cause, upon material or repeated failures of Contractor to comply with the terms and conditions of this Contract, the Department may, by giving thirty (30) days written notice to Contractor, terminate the Contract without giving the Contractor further opportunity to correct said breaches.

Termination for cause by Department pursuant to this subsection shall, in addition to any other rights the Department may have, impose an obligation upon Contractor to (i) fulfill its termination-related obligations including, but not limited to, delivery of pertinent documents, documentation, and related items, in accordance with **Part 3** and either (ii) refund all payments by the Department for work not completed or (iii) reimburse the Department reasonable termination costs.

By the Department upon the entry of a judgment in bankruptcy or insolvency against Contractor, by giving Contractor written notice of termination specifying the date such termination shall become effective. Termination by Department under this subsection shall, in addition to any other rights the Department may have, impose an obligation upon Contractor to fulfill its termination-related obligations including, but not limited to, delivery of pertinent documents, documentation, and related items in accordance with **Part 3**.

By the Department for convenience if it shall have reasonably and in good faith determined that termination would be in the best interest of the State, provided that Department shall give Contractor no less than thirty (30) days prior written notice. The Department shall afford the Contractor reasonable opportunity to present arguments that termination is not in the best interest of the State. Termination by Department pursuant to this subsection shall create an obligation upon Department to pay Contractor the pro rata share of the amount that would have been due for contractual services performed prior to the date of termination. Further, Contractor shall be required to deliver to the satisfaction of the Department those items specified in **Part 3** of the Contract.

By the Department if required by a change in federal or state law or by court order to the extent said change necessitates termination in whole or in part. Termination under this subsection shall create an obligation by the Department to reimburse Contractor for reasonable, direct and fixed termination costs such as rent, severance pay, utilities and/or equipment costs which are unavoidable.

By Contractor for cause, upon a failure of Department to comply with the terms and conditions of this Contract, provided that Contractor shall give the Department written notice specifying Department's breach. In the event that (i) the alleged breach is

related to payment for Contractor's services and within ten (10) days of receipt of notice, the Department shall not have contested, remedied or taken action to remedy the breach alleged or (ii) the alleged breach does not relate to payment for Contractor's services and within thirty (30) days of receipt of notice the Department shall not have either contested or remedied said breach, or for breach which cannot be reasonably remedied in thirty (30) days, commenced in good faith effort to correct said breach, then Contractor may, by giving thirty (30) days advance written notice, terminate the Contract. Termination by Contractor under this subsection shall impose on the Department an obligation to reimburse Contractor the pro rata cost of services performed up to the date of termination and reasonable, direct and fixed termination costs incurred by the Contractor, such as rent, utilities, severance pay and/or equipment costs which are unavoidable.

Upon the expiration date specified in Section 50.400 or in the event the Department elects to extend the Contract pursuant to Section 50.400 on the expiration date specified in the extension agreement.

By either party should federal or state funding for this contact or materials furnished under this Contract become unavailable. Under such circumstances, the Contract shall terminate without termination costs.

In the event of a termination of this Contract under any of the provisions noted above, Contractor shall, pursuant to the Department's written request, provide copies of any documents, work papers, records, magnetic tapes, or reports, of any kind relating to the utilization and quality assurance review services of the Contract. The expression of specific rights of the Department within this Contract addressing a breach by Contractor of its obligations hereunder does not in any way limit or constitute a release or waiver of any other rights or courses of action that the Department may have with respect to said breach.

50.400 TERM OF CONTRACT

The Contract will be for an initial period beginning July 1, 2004, through June 30, 2005, with three (one) year renewal options to be exercised by the mutual agreement of the parties for the period not to exceed June 30, 2008.

The terms and conditions of the Contract shall remain in full force and effect throughout a renewal period, except that reimbursement to Contractor for performance of its contractual obligations may be negotiated by the parties.

50.500 FISCAL SAFEGUARDS

50.501 Bonding

Contractor shall procure and maintain in effect for the duration of the Contract and any extensions thereto a $200,000 performance bond to secure the Department against the cost of obtaining additional assistance because of the non-performance of

Contractor. A performance bond, or other security such as a certificate of deposit, shall be maintained by the Contractor in a form satisfactory to the Department. Contractor liability for penalty payments for late order performance shall not be charged against the performance bond. The bond, certified check, or other acceptable security shall be submitted within two (2) weeks of notification of award.

50.502 Independent Capacity of Contractor

The Contractor shall perform under the terms of the Contract as an independent Contractor and not as an employee, representative, or agent, of either the DHFS or the State of Wisconsin. Neither the State of Wisconsin nor the Department of Health and Family Services shall assume any responsibility for liability or for any costs or damages of any kind whatsoever Contractor may incur directly, or indirectly, as a result of its acts or omissions under this Contract.

The parties hereto agree that Contractor, and any agents or employees of Contractor, in the performance of this Contract shall act in an independent capacity and not as agents, officers or employees of the State.

In addition, the Contractor shall meet the qualifications for independence required under 42 CFR § 438.354(c).

No person acquired or employed by Contractor to perform the services which are the subject of the Contract shall be deemed to be an employee, agent, or servant of the State of Wisconsin or the Department. Accordingly, none of the benefits provided by the State or the Department to its employees, including, but not limited to, workman's compensation and unemployment insurance, are available to the employees of the Contractor employed to perform utilization review services under this Contract.

50.503 Dual Employment

Section 16.417, Wis. Stats., prohibits an individual who is a state employee or who is retained as a consultant full-time by a state agency from being retained as a consultant by the same or another agency where the individual receives more than $5,000 as compensation. This prohibition applies only to individuals and does not include corporations or partnerships.

50.504 Hold Harmless

The Contractor agrees to indemnify, defend, and hold harmless the State of Wisconsin, as well as officers, agents and employees of the state, from all claims, losses, or suits occurring or resulting to any Contractors; subcontractors; laborers; and any person, firm or corporation who may be injured or damaged by the Contractor due to its acts or omissions under the Contract.

A copy of the Contractor's workers compensation insurance policy must be filed with the Wisconsin Medicaid program designated Contract Monitor upon notification of award of Contract.

The Contractor represents that to the best of its knowledge none of the software to be used, developed, or provided pursuant to the Contract violates or infringes upon any patent, copyright, or any other right of a third party. In the event of any action brought against the State or any of its agencies, officers, employees, or agents in which infringement of a U.S. patent or copyright is claimed, the Contractor will indemnify the State and its agencies, officers, employees, or agents against any expenses, costs or damages incurred by the State on account of such claim.

In the event such a claim occurs or in the Contractor's opinion is likely to occur, the Contractor will, at its option and expense, either procure for the State the right to continue using the software or to replace or modify the same so that it becomes non-infringing within a reasonable period of time mutually agreed to between the State and the Contractor.

Contractor shall indemnify the Department or the State of Wisconsin against all liability or loss, and against all claims or actions based upon or arising out of damage or injury caused or sustained by Contractor's personnel in the performance of services under this Contract, or based upon any violation of any statute, regulation or ordinance, in the defense of any such claim or action. Contractor shall assume full responsibility for, and shall indemnify the Department and the State against all liability or loss connected with the payment of all wages, federal and state taxes or contributions imposed or required under Unemployment Insurance, Social Security and Income Tax Law with respect to Contractor's personnel who are engaged in the performance of services under this Contract.

50.505 Conflict of Interest

Any bidder that desires to contract shall, as a prerequisite to approval by the Department, prepare and submit an affidavit that there does not exist a conflict of interest, within the meaning of 42 U.S.C. sec. 1320c-3(b) with respect to performance of any of the review activities which are the subject of the RFB.

During the term of the Contract, neither the Contractor nor any of its officers, employees or agents shall have any interest, direct or indirect, which would conflict in any manner or degree with the performance of services required under the Contract.

Without limiting the generality of the preceding paragraph, the Contractor agrees that it shall not, during the initial term of the Contract and any extension thereto, acquire or hold any business interest relating to the performance of the Contract, except with the prior written approval of the Department.

The Contractor shall not engage in any conduct that violates, or induces others to violate, the provision of the Wisconsin Statutes regarding the conduct of public employees.

50.600 OTHER CLAUSES

50.601 Accounting Systems

The Contractor shall maintain an accounting system in accordance with generally accepted accounting principles and in accordance with appropriate Federal guidelines for the purpose of audit and examination of any books, documents, papers, and records maintained in support of this Contract. All funds under this Contract shall be fully accounted for separately and independently of any other funds of the Contractor. The Contractor shall establish and maintain separate ledgers and checking accounts for the revenues from this Contract, wherein funds shall be clearly identifiable. All disbursements shall be supported by an invoice approved and signed by an appropriate Contractor's representative to document receipt of the materials or services. A separate Accounts Receivable file shall be maintained for each carrier to whom billings are directed and the state shall have access to review it in Wisconsin at any time during normal business hours.

50.602 Inspection of Records

The Contractor shall agree that the State, Centers for Medicare and Medicaid (CMS), the United States Department of Health and Human Services (DHHS), the Office of Inspector General (OIG), and the Comptroller General of the United States including their authorized representatives, until the expiration of five (5) years after final payment for the term of this Contract can examine any of its pertinent books, financial records, documents, papers, and records and those of any parent, affiliated, or subsidiary organization performing under formal or informal arrangement any service or furnishing any supplies or equipment to the Contractor involving transactions related to this Contract. (42 CFR Part 434 Contracts, Subpart A--General Provisions) The Contractor shall also be required to retain and make these records available to State and Federal personnel during normal business hours.

The periods of access and examination described in the paragraph above, for records which relate to (1) litigation or the settlement of claims arising out of the performance of this Contract, or (2) costs and expenses of this Contract as to which exception has been taken by the State, CMS, DHHS, OIG, Comptroller General or any of their authorized representatives, shall continue until such appeals, litigation, claims or exceptions have been disposed of.

The Contractor further agrees that the substance of this clause shall be inserted in each subcontract.

Contractor shall retain and safeguard all pertinent records, documents and other material prepared or utilized in the performance of contractual responsibilities for a

period of five years. Said record retention requirement shall apply to Contractor, notwithstanding a termination of the Contract under Section 50.300. Contractor shall not use or disclose any records, information or material developed or acquired in the performance of its Contractual obligations for purposes not directly related to Contractor's performance under this Contract, without the prior written approval of the Department. The said pertinent records shall be delivered to the Department upon request by the Department.

The Contractor shall agree that authorized personnel designated by either the United States Department of Health and Human Services, Comptroller General or the Wisconsin Department of Health and Family Services may have access at reasonable times to any pertinent books, documents, records of any kind, and computer tapes of the Contractor, involving transactions relating to this Contract. Access shall include the right to examine, audit, excerpt, transcribe or reproduce, any of the subject material. Contractor shall have the right to reproduce said material on the Contractor's premises at a cost not to exceed the cost that would have been incurred if the materials were reproduced off the Contractor's premises. If the information requested is on computer tapes, Contractor will provide copies of the tapes or such computer printouts as may be requested by the Department.

Retention of Contractor's review documentation applicable to the performance of medical record review process will be retained on hard copy. Documentation will consist of all documentation which supports the review determination such as: review worksheets and copies of all correspondence to and from the service provider. Documentation related to a review denial or DRG change will be retained for six (6) years from the date the services were provided. Review documentation related to all other cases will be retained for three (3) years from the review completion date or the duration of the Contract period, whichever is greater.

Medical records of Contractor approved retrospective reviews will be retained for three (3) year after the date the review is completed. Medical records of Contractor denied retrospective reviews will be retained for five (5) years after the date the review is completed. The Contractor will provide the Department with a computer generated list of the medical records that have reached the retention time limit prior to destroying the medical record.

50.603 Confidentiality

Material and information relating to Medicaid recipients provided to the Contractor by the State or acquired by the Contractor in performance of the Contract, whether verbal, written, or otherwise shall be regarded as confidential information in conformance with 42 CFR Part 431 Subpart F, 45 CFR, Parts 160 and 164 and Section 49.45(4), Wisconsin Statutes, and other applicable Federal and State law. All necessary steps shall be taken by the Contractor to safeguard the confidentiality of such material or information in conformance with Federal and State law. Refer to Appendix 5 for provisions of the federal law (42 USC sec.1320c-9), including the criminal penalties.

Contractor shall preserve the confidentiality of all information relating to Wisconsin Medicaid recipients obtained pursuant to its activities under this Contract, in accordance with the provisions of Section 49.45(4), Wisconsin Statutes, and other applicable state and federal law. Contractor shall not utilize any information so obtained in any manner except as necessary for the proper discharge of its obligations or securing its rights under this Contract

50.604 Health Insurance Portability and Accountability Act

The Contractor agrees to comply with the federal regulations implementing the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Parts 160, 162 and 164, to the extent those regulations apply to the services the Contractor provides or purchases with funds provided under this contract. The Contractor has been deemed a "Business Associate" and will be required to sign a Business Associate Agreement. (See template in Appendix 26.)

50.605 Promotion of Minority Business

The Department of Health and Family Services is committed to the promotion of minority business in the state's purchasing program. Authority for this program is found in §. 15.107(2), 16.75(4), 16.755, and 540.036, Wis. Stats. The successful Contractor will be encouraged to purchase services and supplies from minority businesses certified by the Wisconsin Department of Commerce, Bureau of Minority Business Development. The Department of Health and Family Services will require from the successful Contractor a quarterly report of purchases of such supplies and services necessary for the implementation of the Contract.

50.606 Civil Rights Compliance

Refer to Appendix 3, Standard Terms and Conditions (DOA-3054) and Appendix 3A, Supplemental Standard Terms and Conditions (DOA-3681).

50.607 News Releases and Information to Providers or Public

News releases pertaining to this procurement or any part of the proposal shall not be made without prior review and approval of the State of Wisconsin, Department of Health and Family Services.

50.608 Right to Publish

The Contractor will be allowed to make public oral presentations, to write and have such writing published subject to the Department's review and approval before public release of the information on subjects associated with the work under this Contract.

50.609 Documentation

Notwithstanding any provision in this Contract to the contrary, the standards, formats and forms for all documentation required of Contractor hereunder shall be mutually agreed upon by Department and Contractor and shall, including all criteria developed or revised by the Contractor for work performed under the Contract, become the property of the Department.

50.610 Choice of Law

The Contractor agrees to be bound by the laws of the State of Wisconsin and to bring any legal proceedings arising under the agreement to mutually agreed arbitration prior to bringing any legal proceedings arising under the Agreement in a court of the State of Wisconsin. For the purpose of Federal jurisdiction, in any action in which the State of Wisconsin is a party, venue shall be in the United States Western District Court for the State of Wisconsin.

50.611 Severability

If any provision of the Agreement is found to be illegal, unenforceable, or void, then both parties shall be relieved of all obligations under that provision. The remainder of the Agreement shall be enforced to the fullest extent permitted by law.

50.612 Force Majeure

The Contractor shall be excused from performance hereunder for any period that it is prevented from providing, arranging for, or paying for services due to unforseeable causes beyond the control and without fault or negligence of the Contractor and that could not reasonably have been avoided or overcome by the exercise of due care on the part of the Contractor. Such causes include acts of God, fires, strikes by other than the Contractor's employees, freight embargoes, and similar phenomena.

50.613 Access to and inspection of the Contractor's Premises

To assure Contractor's compliance with the Contract, the duly authorized agents or representatives of the Department shall at all times be accorded access to Contractor's premises or the premises of the Contractor's subcontractors to inspect, audit, monitor or otherwise evaluate the performance of the Contractor's or subcontractor's activities. This access is throughout the duration of the Contract, and for a period of five (5) years after termination of the Contract.

In the event right of access is requested under this Section, the Contractor or subcontractor shall provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the Department personnel conducting the audit or inspection effort.

50.614 Records Retention

Contractor shall retain, preserve and make available upon request all order forms, other forms, records and documents relating to the performance of its obligations as specified under the Contract. Contractor shall retain such documents, whether maintained in paper or in any other form, along with their documentation for computer generated reports, for a period of not less than five (5) years from the date of termination of the Contract. Records involving matters which are the subject of litigation shall be retained for a period of not less than five (5) years following the termination of litigation, if the litigation is not terminated within the normal retention period.

Upon expiration of the five (5) year retention period, the subject records shall, upon request, be transferred to the Department's possession. No records shall be destroyed or otherwise disposed of without the prior written consent of the Department.

60.000 PAYMENTS, PERFORMANCE REVIEW, AND LIQUIDATED DAMAGES

60.100 PAYMENT FOR CONTRACTOR SERVICES

The Contractor shall submit an invoice to the Department on a schedule to be mutually determined by the parties. The cost per review includes all costs for the review. The Contractor's proposal shall exclude reimbursement to the Contractor for hospital and HMO photocopying of medical records.

The "cost per review" stated by the successful bidder on the Review Time and Cost Report will be used in determining the maximum payment to the Contractor for Fixed Administrative/General and Direct Reviewer Costs associated with performing the contract services.

It is expected that the Contractor will bill monthly. The monthly payment for Direct Reviewer costs will be calculated from cost information submitted by the Contractor in the Review Time and Cost Report form (Appendix 6B) and noted below.

The payment for Fixed Administrative and General (fixed A&G) costs will be a flat monthly payment calculated from a sum of total costs of (1) Allocated Share of Other Direct and Indirect: Column 12 line (A-O) Total and (2) the totals of the Direct Reviewers Costs; Column 10.

The payment for Direct Review Costs will be paid monthly on the basis of actual completed cases stated in the workload report and specific to the following review categories:

- Non-HMO Inpatient Hospital reviews
- MCOs, SMCOs, FFS reviews

The Department will reimburse the Contractor only for those retrospective reviews completed by June 30, 2005.

The total payment to the Contractor for this contract period, July 1, 2004, through June 30, 2005, shall be no more than total costs (Column 13).

No changes in reimbursement are permissible except upon contract extension. Any changes in reimbursement must be based on verified changes in Contractor costs. In no event shall any negotiated increases in Contractor reimbursement applicable to the contract extension periods exceed the lesser of the following:

1. Limitations imposed on the Department for the Medicaid program by the Wisconsin Legislature; and

2. Three percent increase to total price of the previous contract.

60.200 MEDICAL RECORD PHOTOCOPY VERIFICATION AND PAYMENT

The Contractor shall process at least quarterly, hospital, Special Managed Care and Managed Care (MC) providers and fee-for-service (FFS) physician requests for payment of medical record photocopying requested by the Contractor for review under the contract. The Contractor shall maintain a record of the number of pages received from each hospital, HMO providers, and FFS and the amounts billed by each. The rate of photocopying reimbursement during the initial contract period shall be $.07 per page, plus the postage or equivalent shipping costs. The cost of this activity shall not be included in the Contractor's cost proposal.

The Contractor shall reimburse hospitals, HMOs providers and FFS physicians at least quarterly per contract year and maintain a log of the number of photocopies claimed and the amounts reimbursed per hospital, HMO provider and FFS provider. The Department, upon receipt of a photocopy invoice from the Contractor shall pay the Contractor the amount of the actual direct payments made to the hospitals, HMO's providers and FFS providers for reimbursement of photocopying medical records.

60.300 PERFORMANCE REVIEW AND STANDARDS

The Contractor must comply with all the requirements and specifications contained in this RFB as well as any changes thereto. In addition, all requirements described in the RFB are subject to monitoring by the Department or its designee. The Department reserves the right to monitor performance and may exercise such option at its discretion without notice. The results of such monitoring will be used to provide a basis for improved review activity and enforcement of contract terms and provisions.

60.400 LATE START DAMAGES

The Department claims, and the Contractor acknowledges, that time is of the essence in the performance by the Contractor to the proposed start date July 1, 2004. Further, the Contractor acknowledges that damages will be incurred by the Department, in the amount of $5,000 per working day for every day past the scheduled contract start date. The Contractor agrees that the state shall have the right to liquidate such damages, through the deduction from the Contractor's invoices, in the amount equal to the damages incurred, or by direct billing of the Contractor.

60.500 LIQUIDATED DAMAGES FOR NON-TIMELY PERFORMANCE OF CONTRACTOR OBLIGATIONS

The Contractor shall, at all times, comply with all requirements specified in the contract. Further, it is required that the Contractor adhere to the timeframes developed

for the accomplishment of each health care review responsibility outlined in **Part 3**. The specific timeframes for each review can be found in the Sections of **Part 3**.

The Contractor shall provide the Department with written reports that are clear, concise and useful for the audience for whom they are intended. The reports shall be composed in a manner consistent with Department specifications and with the Contractor's stated criteria. All reports shall be provided in electronic formats compatible with software applications in use by the Department (i.e., MS WORD, Excel, etc) as well as in hard copy, as specified by the Department. The Contractor is responsible for assuring that it completely understands the specifications and requirements for all reporting and other activities under the contract. Where required, the Contractor shall provide supporting documents such as appendices for the report.

In the event of a failure to meet the requirements as described above, the Contractor agrees to pay to the Department liquidated damages, at the Department's discretion. Damages in the amount of up to $1,000 may be assessed for each day after the designated timeframe for correction/submission until the correction/submission of Contract non-compliance.

If the Department elects to not exercise a damage clause in a particular instance, this decision shall not be construed as a waiver of the Department's right to pursue associated damages or other remedies, including contract termination, for failure to meet that performance requirement in the future.

70.000 CONTRACTOR SCOPE OF SERVICES

The scope of health care review services to be performed by the Contractor, performance requirements for review activities, and the review and report specifications are set forth in this part.

The Division of Health Care Financing (DHCF) has established review processes for monitoring of care for medical necessity, appropriateness, and quality in both the ambulatory and hospital arenas for Fee-for-Service (FFS) and managed care providers. The established review processes permit the DHCF to meet the federal mandate requiring an annual independent review of health care services that are delivered to Medicaid recipients enrolled in the Wisconsin Medicaid program.

In addition to the review activities described in this contract, the Contractor shall assist the Department with activities on an as needed basis with mutual consent of the DHCF and Contractor. When necessary, funds shall be made available from other parts of the External Quality Review Organization (EQRO) Contract budget to pay for these additional activities.

70.001 Review-related Services

Health care review services include the comparison of health care information to identifiable criteria and to the professional judgment of licensed health care providers. The review assists the Department of Health and Family Services in its reimbursement decisions and in the monitoring of quality of health care provided to Wisconsin Medicaid recipients. The Contractor shall perform the review services set forth in **Part 3** in accordance with applicable professional standards and the requirements of Title XI, Part B, of the Social Security Act: U.S.C. sec. 1320c, et. Seq.

Generally accepted norms, criteria and standards of care shall be applied in the peer review process and may be specified by the Department. In all cases, criteria applied by the Contractor for any review shall be approved by the Department.

Admission review means a review and determination by the Contractor of the medical necessity and appropriateness of a patient's admission to a specific facility.

Quality of care review means a review and determination by the Contractor that the care provided was medically necessary and appropriate, timely and consistent with generally accepted standards of medical and nursing care applicable in the setting being reviewed. Review for quality of services provided requires documentation that a DHCF approved screen for quality review be employed.

Validation of data means verification with documented service provision, utilization and diagnostic data submitted by HMOs or other capitated providers is carried out to assure accurate and complete data; and that data submitted by providers is consistent with Medicaid requirements, and meets HIPAA requirements.

70.002 Sampling

The Contractor shall use appropriate statistically valid random sampling for selecting cases for review as directed by the Department. The sampling will include a DHCF approved level of confidence and significance. The Contractor will provide a description of the formula and rationale for deriving the sample. The Contractor will provide to the Department on demand, a defense of the sampling.

70.003 RN and Physician Reviewers

Contractor RN reviewers shall hold a valid Wisconsin License and be experienced in the performance of health care reviews and appropriately trained in the comparison of health care information to specified utilization, quality, and generally accepted standards of care criteria.

Contractor shall have available to it, by arrangement or otherwise, the services of a sufficient number of licensed doctors of medicine and/or osteopathy, practicing medicine and surgery in the review area, to assure adequate peer review of the services provided by the various medical specialties and subspecialties. The Contractor must demonstrate arrangement or arrangements with at least one available physician in each generally recognized subspecialty.

Peer review medical judgments shall be made by licensed physician reviewers engaged in the practice of medicine and who have active staff privileges in a Wisconsin hospital. Active staff privileges means:

1. That a physician is authorized on a regular, rather than infrequent or courtesy, basis:

    a. To order the admission of patients to a facility; or
    b. To perform diagnostic services in a facility; or
    c. To care for and treat patients in a facility.

2. That a health care practitioner other than a physician is authorized on a regular, rather than infrequent or courtesy, basis to order the admission of patients to a facility.

70.004 Other Review Personnel

Contractor review personnel shall include personnel who have a thorough understanding of epidemiology and statistical methods for the measurement of health status indicators in defined populations, including:

- Scope and methodology of data collection
- Interpretation of data
- Understanding of the social and economic factors that affect data interpretation.

The activities to be undertaken by the Contractor include designing, assessing and implementing performance improvement projects. Hence, the Contractor must have state of the art expertise in research methods and statistical analysis methods sufficient to undertake these activities. The written reports must be prepared in formats that are easily understood and useful to specific clients, and to instruct Medicaid HMOs, as necessary, in how and where to undertake such studies.

70.005 Restrictions

Contractor is not licensed to practice medicine and does not provide health care services or treatment such as may be provided by a physician or a hospital, nor does it make any decisions or determinations, which may direct the actual provision of health care services or treatment.

70.006 The External Quality Review Organization Rule Established Requirements

The Centers for Medicare and Medicaid (CMS) EQRO rule establishes requirements and procedures for the external quality review of Medicaid managed care organizations (MCOs). The rule implements section 1932(c)(2) of the Social Security Act (the Act), which was enacted in section 4705(a) of the Balanced Budget Act of 1997 (BBA), and section 1903(a)(3)(C)(ii) of the Act, and which was enacted in section 4705(b) of the BBA. The full scope of work under the contract to be awarded subsequent to the RFB process shall include specific guidance to the EQRO Contractor based on the CMS EQRO Protocols incorporated by reference herein." See Appendix 27 for a summary of the CMS protocols.

70.007 Contractor Convening Open Meetings

The Contractor shall be responsible for convening meetings in accordance with the Open Meetings of Governmental Bodies found in Section 19.81 - 19.98 of the Wisconsin Statutes whenever the meeting agenda includes discussions of topics directly or indirectly related to responsibilities described in the Contract with the Department.

The Department is responsible for the development and distribution of the public notice associated with the open meetings convened by the Contractor. The Contractor shall provide the Department with the agenda, location and time for the meeting two weeks prior to the meeting. The Contractor shall provide the Department with a written summary of the meeting minutes no later than two weeks following the meeting. In the event of a cancellation, the Contractor shall send the Department written notice two (2) working days prior to the cancellation.

70.008 Support During Administrative Hearings

The Contractor shall provide to the Department on demand, any documents related to a review procedure that results in a final denial determination in Wisconsin Medicaid. In addition, all individuals (e.g., physician reviewers, RN reviewers) involved in a review resulting in the denial determination shall be available to the Department for testimony and discovery pursuant to any administrative hearing. All of these activities shall be done in a manner that does not conflict with federal law. The cost of physician advisors or consultants shall be billed to the Department on an actual cost per case basis and shall not be included in the proposed budget.

70.009 Physician and/or Expert Consultation

At the request of the Department, the Contractor shall designate an appropriate physician and/or panel of experts to review the status of procedures, devices, and/or medical services in current medical practice. Upon direction from the DHCF Chief Medical Officer, the Contractor shall select practicing physicians and/or experts in the relevant fields to exchange information either by writing, e-mail, conference calls, or face-to-face consultation. The Contractor shall maintain a record of the findings and forward them to DHCF.

In addition, prior to any meeting or exchange, the Contractor will compile and distribute current relevant information that has been approved by the DHCF chief medical officer. Refer to Appendix 29 for further description of the Physician/Expert Consultation.

70.100 ADMINISTRATIVE FUNCTIONS

70.101 Maintaining and Updating Review Criteria

The Contractor shall systematically review existing review criteria with Contractor's internal physician committees, other professionals, the Department, Medicaid Health Maintenance Organizations (HMOs) medical directors and practicing Medicaid-certified physicians. Contractor shall update existing review criteria, including rationale/citation for changes in criteria, on a biennial basis. The authoritative source for review criteria will be included as part of the review criteria set, and shall include the date the criteria was established. All changes to existing criteria must be approved by the Department and disseminated to Medicaid providers prior to use in the review process(es).

70.102 Development of New Utilization and Quality of Care Criteria

Development of new utilization and quality of care criteria as needed and/or requested by the Department. These criteria will be developed in conjunction with the appropriate professional/advocacy groups and must be approved by the Department prior to implementation.

70.103 Uniform Charting Techniques

The Contractor shall encourage the use of uniform charting techniques for specific indicators such as prenatal care and infant/child wellness checks.

70.104 Data Management

The Contractor shall employ and promote universally accepted data management techniques and reporting standards, including putting into effect applicable industry-accepted review measures, development and maintenance of a secure Internet data transfer system between the Contractor and the Department, and compliance with all relevant HIPAA requirements.

70.105 Tracking Changes in the Scope of Work

The Contractor, in cooperation with DHCF, shall track any substantial change or departure from the nature and scope of work set forth in this contract. Directives will be used as a form of documentation and communication between the Contractor and DHCF. Directives shall follow the format outlined in Appendix 19.

The Contractor, in cooperation with the DHCF, will submit a directive for any requested change in scope of work. This includes but is not limited to, requests for format changes of reports, substantial re-writing of ERO submitted reports, and additional reviews of health care services provided to recipients in programs administered by the DHCF.

70.106 Develop and Present Educational Activities

The Contractor shall annually develop and present educational activities that present and interpret DHCF quality improvement activities/results to promote Medicaid providers' understanding and compliance with criteria. The educational activities may include publishing reports regarding review findings related to Medicaid FFS or managed care service delivery, seminars, video-conferences, etc. The Contractor shall work cooperatively with Medicaid HMO medical directors and the Department regarding the development and presentation of the educational activities. The educational activities may include:

- Best Practices Seminar for Managed Care Organizations (MCOs) – This seminar is a one (1) day event that will take place every year unless otherwise determined by the DHCF chief medical officers. Prior to the seminar, the DHCF QA committee will select the Performance Improvement Projects (PIPs) to be presented based upon the recommendations of the DHCF chief medical officers. On the day of the seminar HMO personnel will present their PIPs with a review from a panel of no fewer than three experts in the Quality Assurance and/or Health Care areas providing critique. The Seminar will have AM and PM sessions with lunch and a speaker provided between sessions. The seminar will

terminate with a summation of events by the DHCF chief medical officer and/or the bureau director of managed care.

- Time Frame – Planning is to begin with the completion of the PIP in December of each year. The seminar will occur no later than six months after the PIPs have been completed.

70.200 NON-HMO DENIAL PROCESS

The Contractor will review documentation in the medical record and make an initial determination on medical necessity. If the hospital or attending physician disagrees with the proposed initial determination, a request by the hospital or physician for reconsideration may be made in writing within thirty (30) calendar days of the date of the Contractor denial letter. The medical record and other relevant information will be referred to Contractor's physician reviewer for a reconsideration of the denial. (See Appendix 15, Reconsideration Process.) The attending physician and hospital will receive written notice of the final review decision by the Contractor within fifteen (15) working days of the reconsideration review decision.

70.201 Denial of Inpatient Hospital Admissions

In the event the physician reviewer determines that the admission was not medically necessary, Contractor will implement a Proposed Admission Denial Notice (see Appendix 13). If the hospital or attending physician disagrees with the proposed initial determination, the Contractor will follow the process detailed in section 70.100 (see above).

70.202 Denial of Outpatient Services

In the event the physician reviewer determines that the outpatient service was not medically necessary, Contractor will implement a Proposed Outpatient Service Denial Notice (see Appendix 13). If the outpatient facility or attending physician disagrees with the proposed initial determination, the Contractor will follow the process detailed in section 70.100 (see above).

70.300 NON-HMO SANCTIONS

When the Contractor becomes aware of possible non-managed care Medicaid violations, the Contractor shall apply the sanction recommendation process (Appendix 14) to a physician or institution. The costs of each sanction recommendation based on Medicaid cases only, shall be charged on an actual cost per case basis, and require prior approval of this action by DHCF. The budget for this activity is not included in the RFB proposed budget. The Medicaid program violations which apply to this sanctioning recommendation process will occur when the provider has prescribed, provided, or claimed reimbursement for services under the program which were either:

1. Inappropriate;
2. Unnecessary or in excess of recipient needs;
3. Detrimental to the health or safety of the recipient; or
4. Of grossly inferior quality.

The final results of the action shall be forwarded to the DHCF Administrator. The Contractor shall also notify the DHCF chief medical officer and designated contract monitor on a quarterly basis of any sanctions of physicians or institutions in progress for the Medicare program, within prevailing confidentiality statutes and regulations.

70.400 REPORTING OF REVIEW ACTIVITY

Contractor shall submit review activity reports as noted in the ensuing sections of this RFB.

The Contractor shall be responsible for monitoring the completeness of reports which are required in the RFB, the timely evaluation, including a detailed analysis, of reports submitted to the DHCF, and follow up on recommendations made, including analysis and tracking of corrective action plans and implementation by providers, where appropriate.

70.500 RECOUPMENT ADJUSTMENT PROCESS

The Contractor will review the documentation for Inpatient DRG and CON potential recoupments. The Contractor will send the potential recoupment database to DHCF on a quarterly basis. DHCF will verify the potential recoupment and send the database back to the Contractor to verify that the dollar amount was not adjusted. The Contractor will query the adjustment database and adjust the potential recoupments as appropriate. The Contractor will then return the database with the adjusted amounts to DHCF to generate the letters for recoupment. (See Appendix 28 Diagnostic Related Group - Data Validation Flow Sheet)

70.600 CONTRACTOR QUALITY OF CARE REVIEW TRACKING

The Contractor shall implement a quality of care and service review system which identifies and categorizes quality of care issues and service concerns by service, type of deficiency, provider, managed care organization, and severity level. In addition, the Contractor shall conduct, analyze and report quality of care findings in a uniform manner, which can be used by providers and the Department in developing effective intervention strategies. Refer to Appendix 18 for a description of the review system.

The Contractor must establish a process of continuous quality improvement for Medicaid recipients treated under fee-for-service and under managed care. The objective is to develop and share with health care providers and managed care organizations information on patterns of care and patient outcomes so that the information will result in improvement of care provided to Medicaid recipients. The Contractor shall be required to share this information with physicians, other providers

and managed care organizations as agreed upon with the Department to assist them in identifying ways to achieve improved patient outcomes.

The Contractor shall maintain a database of the results of its quality improvement activities and demonstrate a capability to track the status of its activities on each project in progress. The Contractor shall develop a management plan for reporting its QI activity that includes tracking a corrective plan of action in response to data analysis, where appropriate, and planned continuing monitoring of activity will take place to verify that the corrective action plan was appropriate and effective.

80.000 REVIEW CATEGORIES AND RELATED ACTIVITIES

The categories of case review activity to be performed by Contractor are set forth in this part.

For each category, the review objective, the scope of services subject to review, the basis for case selection, and the review methodology are specified. Refer to Appendix 11 for a description of the review process. The protocol for denials and reconsideration are documented in Appendices 13, and 15 to this RFB, and apply to all case reviews. Unless otherwise stated, all hospitals in Wisconsin are to be subjected to Contractor hospital medical review activity. All results of hospital case review activities shall be reported to the Division of Health Care Financing (DHCF), Department of Health and Family Services (DHFS) in accordance with the reporting requirements specified under this RFB.

80.100 ADMISSION REVIEW

80.101 Review Objective

The purpose is to reduce the number of inappropriate or unnecessary hospital admissions of non-HMO Medicaid recipients, and to reduce admissions for procedures that could be performed effectively and with adequate assurance of patient safety in an ambulatory setting.

80.102 Scope of the Review

All elective medical admissions, whether reviewed prior to admission or those undergoing delayed admission review, except admissions for maintenance chemotherapy, and elective admissions for those surgical procedures that have been included on the Contractor's Outpatient/Ambulatory Surgical Procedure List are subject to admission review. (See example in Appendix 10.)

Contractor shall inform the DHCF chief medical officer and designated contract monitor and all Wisconsin hospitals by mail, whenever the Outpatient/Ambulatory Surgical Procedure List is updated by the Contractor, subsequent to approval by the Department. At least thirty (30) days notice of new admission review procedures or of additions/deletions to the Outpatient/Ambulatory Surgical Procedure List must be given to hospitals and the DHCF prior to Contractor implementation. It is the Contractor's responsibility to update the Ambulatory Surgical Procedure List no less than on a biennial basis and record the date of update on the procedure list.

80.103 Review Method

The review process is initiated by a telephone call from the attending physician or his/her representative. The attending physicians or their representatives shall present patient information by telephone to Contractor nurse reviewers prior to the planned admission. The Contractor nurse reviewer shall evaluate the patient information in terms of appropriate specialty-developed admission screening criteria. Through this evaluation, the case shall be classified into two categories; (1) the case meets admission screening criteria, (2) the case does not meet admission screening criteria.

Any case that does not meet the screening criteria as determined by the Contractor nurse reviewer shall be referred to the Contractor's physician reviewer. The physician reviewer shall review the medical record. If, subsequent to review, the physician reviewer determines that the case lacks medical necessity for admission, the practitioner shall be advised that the case does not meet admission criteria and the case shall be retroactively reviewed for medical necessity and appropriateness of care.

Upon completion of telephone Admission Review (AR), the Contractor shall issue in each case a specific review control number (which is currently 10 digits in length). Contractor will instruct providers to record this number on the hospital claim form. The number reveals to the fiscal agent that an AR was performed. The Contractor shall propose an approach to maintaining integrity of the system (e.g., duplicate AR numbers, dealing with provider ownership changeovers). (The current format of the review control number appears in Appendix 7 to this RFB.)

80.120 Delayed Admission Review

A delayed AR occurs when a provider fails to obtain a review control number prior to admission.

80.121 Review Objective

The purpose of this review is to evaluate the reasonableness, necessity, and appropriateness of a hospital admission which should have undergone admission review but which failed to do so.

80.122 Review Scope

The Medicaid fiscal agent denies payment for all claims, which require an admission review control number if an admission control number is not indicated on the claim. An Explanation of Benefits (EOB) code appears on the provider's remittance advice when an admission is denied because no admission review was performed. The EOB code directs the provider to contact the appropriate Contractor office to seek review, and obtain a review control number, which shall permit payment in appropriate cases. The provider who failed to obtain a review control number through an admission review initiates the delayed review of admission.

80.123 Review Method

Attending physicians, or their representatives, submit copies of the medical record for review, requesting the Contractor to review the admission. The Contractor nurse reviewer evaluates the patient information in terms of the screening criteria used for admission review. The case is classified into one of two categories: (1) case meets admission screening criteria and is assigned a 10-digit case-specific control number, (2) case does not meet admission screening criteria, and is referred to Contractor's physician reviewer.

Contractor will follow the procedures presented in Section 70.200 for cases that are not approved.

80.200 RETROSPECTIVE REVIEWS

80.210 Targeted Admission

80.211 Review Objective

The purpose of retrospective targeted review is to assure that the Medicaid payment for inpatient hospital care is reasonable, necessary and appropriate and to review the completeness, adequacy, and quality of care provided to Wisconsin Medicaid recipients.

80.212 Review Scope

All cases are subject to retrospective review. The Contractor shall perform retrospective review on inpatient hospital stays for the contract period in accordance with a priority hierarchy. DHCF may elect to alter this hierarchy at anytime as deemed necessary and will notify the Contractor when this occurs.

80.213 Review Method

Contractor shall arrange with the Medicaid fiscal agent to receive paid claims data that are required to perform the activities in Part 3. Upon receipt of inpatient hospital claims data from the DHCF's fiscal agent, Contractor will identify all cases subject to retrospective review pertinent to the hierarchy (see Appendix 17). It is the Contractor's responsibility to identify and select cases from paid claims data. Contractor shall select a percentage of cases from each type of targeted hospitalization from each of the monthly paid claim tapes to distribute case selection equitably over the contract year to all Medicaid hospitals. Furthermore, the sample will be a statistically valid sample; the statistical method of such sample selection will be approved by the DHCF prior to implementation. Contractor shall select only inpatient claims, which indicate a patient discharge status code of 01-08 or 20 in item 22 of the hospital claim form (UB-92). All other hospital cases subject to retrospective review shall be selected from paid claims data pertinent to the hierarchy and number of cases identified in Appendix 17 within the contract period.

Contractor's inpatient cases shall be from the paid claim tapes for the period of the Contract Year (CY). Paid claim tapes for each quarter of the CY shall be made available sixty (60) days following the end of that quarter. In the event that the total number of hospital review cases selected in any month is exceeded, cases shall be eliminated according to the hierarchy described in Appendix 17 until the correct number of review cases is attained prior to the Contractor mailing request for medical records to hospitals.

The DHCF fiscal agent shall send the Contractor paid claim tapes consistently during the contract year for review selection. Logistical problems which result in Contractor's inability to obtain or use the paid claims tapes provided by the DHCF fiscal agent on a timely basis are to be identified and reported to the DHCF chief medical officer and designated contract monitor immediately. Contractor shall be notified of changes in the paid claims tape format and content by the DHCF fiscal agent. All selected retrospective reviews shall be completed and reported to the DHCF on or before the end of the contract period.

80.220 Short Stays

Contractor shall retrospectively review all cases that have a length of stay of zero, one or two days, with the following three exceptions:

1. Claims involving a delivery diagnosis: DX. Codes: 372 – 375 vaginal deliveries and 370 – 371 c-sections.

2. Hospitalization for maintenance chemotherapy: DRG 410 and 492; DX Code V581.

3. Newborn claims – Admit "4" on field 17 of claim.

80.230 Readmissions

Contractor shall perform retrospective review of hospital admissions of patients which take place within thirty-one (31) days of the patient's discharge from a hospital and determine if the patient was prematurely discharged during the prior admission.

When two admissions for the same patient ID number are identified, the second admission is defined as a readmission if the admit date of the second admission is thirty-one (31) days or less from the discharge date of the first admission. Appendix 12 presents specific methodologies for retrospective review of selected readmission cases. Cases excluded from readmission review are:

1. Hospitalization for maintenance chemotherapy: DRG 410 and 492; DX Code V581.

2. Sickle-cell crisis: DX Code 282.62.

3. Readmission pair where the second case is a delivery: DRGs 372 – 375 vaginal deliveries and 370 – 371 c-sections.

80.300 RECONSIDERATION OF RETROSPECTIVE DENIAL

Contractor shall make an initial determination that an admission is not medically necessary only after a physician acting on behalf of Contractor has performed a retrospective medical chart review. A hospital is entitled to a reconsideration of Contractor's initial determination.

A hospital must submit a written request for a reconsideration review to Contractor within thirty (30) days from receipt of Contractor's original determination. Contractor shall then conduct the reconsideration review and shall issue a final determination in writing to the hospital within fifteen (15) working days of the reconsideration review decision.

If a hospital does not request a reconsideration review within sixty (60) days from the receipt of Contractor's original determination, Contractor's initial determination becomes a final determination. A formal written notice from Contractor of all adverse initial and final decisions shall be issued to the hospital, attending physician and the DHCF chief medical officer and designated contract monitor.

80.400 CASES REFERRED BY DHCF

80.401 Review Method

Selected cases may be referred in writing by DHCF to Contractor for review. Contractor shall review and separately report back to DHCF chief medical officer and designated contract monitor on the admission necessity, appropriateness of the length of stay and quality of care of any case referred.

80.500 MENTAL HEALTH/SUBSTANCE ABUSE SERVICE REVIEW

80.510 Inpatient MH/SA Review

80.511 Review Objective

The purpose of the Mental Health/Substance Abuse (MH/SA) review is to determine the medical necessity and quality of MH/SA of medical services provided to Medicaid recipients. Medical necessity implies that the inpatient hospital care is medically necessary to assure the health and safety of the recipient and others.

80.512 Review Scope

MH/SA review shall apply to admissions, specialty or general acute care hospitals with one or more of the following admitting or primary discharge ICD.9.CM diagnosis codes:

- Substance Abuse: 291 - 292.99; 303 - 305.99
- Mental Health: 295 - 302.99; 306 - 309.99; 311 - 316.99

80.513 Review Method

The Contractor shall be responsible for applying applicable criteria to MH/SA hospital admissions. Distinct criteria shall be used for adults, children, and eating disorders.

80.520 Telephonic Admission Review

80.521 Review Objective

The purpose of telephonic admission review is to reduce the number of inappropriate or unnecessary hospital MH/SA admissions.

80.522 Review Methods

The admitting physician or hospital shall contact the Contractor for the MH/SA hospital AR of Medicaid recipients. Depending upon the screening results, the cases shall be approved or designated as "suspect" cases. All reviewed cases shall be assigned a control number.

80.530 Suspect Admissions Review

80.531 Review Objective

The purpose of suspect admission review is to determine if an admission is medically necessary.

80.532 Review Method

If the reviewer determines that the admission appears to not be medically necessary:

1. The Contractor shall inform the hospital or physician who contacted the Contractor by telephone that the admission is "suspect" and issue a control number.

2. The Contractor shall flag the case for retrospective review as a "suspect" case.

3. The Contractor shall conduct a retrospective review on all MH/SA cases deemed to be "suspect." The Contractor shall request a copy of the patient's medical record from the hospital. If upon retrospective review of the medical chart the Contractor determines that any portion of the inpatient stay was not medically necessary, the Contractor shall inform the hospital, physician and the DHCF of the determination in writing.

80.540 Delayed Review of MH/SA Admission - (See 80.120)

80.550 Retrospective MH/SA Chart Review

80.551 Review Scope

Medical charts selected for MH/SA retrospective review, for any reason, shall undergo quality of care review.

80.552 Review Method

Contractor's nurse reviewers, using Department-approved quality of care screens or where the screen is not applicable, using professional judgment shall evaluate each case. Cases judged to have quality of care problems shall be referred to a physician reviewer for confirmation. Each confirmed quality of care problem identified shall be forwarded to DHCF. The Contractor shall record all quality of care problems and report this data by hospital and practitioner to the DHCF chief medical officer and designated contract monitor on an annual basis.

Contractor shall conduct a retrospective review of admissions in the following hierarchy:

1. All Institutions for Mental Disease (IMD) hospitalizations of Medicaid recipients under the age of 21.

2. Inpatient SA hospitalizations with lengths of stay zero through two days.

3. Inpatient mental health or SA hospitalizations identified as a preadmission review suspect admission.

4. In the event a case qualifies for more than one of the admissions, the case shall be assigned for reporting purposes to the category with the highest hierarchy ranking.

80.560 Retrospecitve MH/SA Chart Review of Special Cases

80.561 Review Objective

The purpose of the Retrospective Medical Review of Special Cases and Circumstances is to provide an alternative review format to be used in special circumstances.

80.562 Review Scope

Hospitals located in certain states outside of Wisconsin that regularly provide service to Medicaid recipients (Border Status Hospitals) are included in MH/SA reviews. A listing of these institutions can be found in Appendix 9. All court ordered admissions are subject to MH/SA review (all admissions with **UB-92 item 20 with source code 8).** Medicare/Medicaid eligible recipients are subject to retrospective review only when a recipient has exhausted inpatient benefits under Medicare.

80.563 Review Method

Cases in which an application for Wisconsin Medicaid is submitted at the time of admission or at any point during the inpatient stay are subject to MH/SA review as follows:

1. Cases in which a patient is not a Medicaid recipient at the time of admission, and the patient applies for Medicaid coverage of the hospitalization during or after the stay. Immediately following a determination of eligibility, the hospital shall notify the Contractor of the MH/SA hospitalization prior to submitting the claim so that the Contractor can assign a Medicaid reimbursement control number to the case.

2. Separate Case Eligibility admissions and stays: Separate case eligibility is Medicaid eligibility determination based on a child's income assets when a child is admitted to a specialty hospital with the expectation of a prolonged inpatient stay.

80.570 Exempted MH/SA Cases

1. Medicaid-contracted managed care recipients are exempted from MH/SA review.

2. Out-of-state hospital admission and stays (excluding border status hospitals) are exempted from MH/SA review.

80.580 Retroeligibility Cases

80.581 Review Objective

The purpose of the review is to assess the need for admission from the date of Medicaid eligibility. Instances of separate case eligibility fall into this category.

80.582 Review Scope

When a patient is not Medicaid-eligible at the time of admission, but becomes Medicaid-eligible either while in the hospital or following discharge, the hospital shall contact the Contractor for a MH/SA review control number prior to submitting the reimbursement claim.

80.583 Review Method

The Contractor's assessment shall be based on information provided by team evaluation regarding the patient's clinical condition from the date of Medicaid eligibility. Cases identified for review prior to discharge, but after admission, due to retroeligibility, will be "suspect" and targeted for retrospective chart review only when admission criteria are not met.

80.600 REVIEW FOR QUALITY OF CARE

80.601 Review Scope

All inpatient cases selected for retrospective review shall undergo quality of care review.

80.602 Review Method

Contractor reviewers shall employ Department-approved quality of care screens or where the screen is not applicable use professional judgment to review for quality of care. Reviewers shall evaluate each case with regard to complications (e.g., nosocomial infections and iatrogenic injuries), medication and transfusion errors, and medical stability at discharge, documentation of planned follow-up, among other indicators of quality of care.

The Contractor will forward each quality of care problem confirmed by a physician reviewer along with case specific information to the DHCF chief medical officer and designated contract monitor. This information will be provided to DHCF on a scheduled basis in the form of a summary description of the quality of care problem. The reporting of quality of care problems may be more frequent, depending on the profiling activities of the Contractor identifying problem(s) requiring immediate action.

The Quality Review Process and reporting is outlined in Appendix 18. The Contractor may propose other methods for the quality review process.

The Contractor shall record each quality of care problem and annually report this data by hospital and/or practitioner to the DHCF chief medical officer and designated contract monitor.

80.700 DRG/DATA VALIDATION REVIEW

80.710 DRG/Data Validation Review

80.711 Review Objective

The purpose of the DRG/Data Validation Review is to accurately and consistently validate paid claims data to assure that data submitted by providers for claims payment reflects the diagnoses, procedure(s), and circumstances of the case as documented in the medical records.

80.712 Review Scope

The Contractor shall perform data validation of all cases selected for retrospective review.

80.713 Review Method

The Nurse/Certified Coding Specialist/RHIA, RHIT performs case review and will validate that the following elements are substantiated in the medical record:

1. Diagnoses – principal and secondary codes (correct assignment of ICD-9-CM codes)
2. Procedure codes (correct assignment of ICD-9-CM codes)
3. Patient Admit Status (Elective, Urgent, or Emergent)
4. Admit Date
5. Discharge Date
6. Discharge Disposition
7. Sex
8. Date of Birth

The Contractor shall install the 3M DRG Grouper version in effect for the dates of service under review. Sufficient information has been furnished in Appendix 8 for the Contractor to program additional Wisconsin Medicaid DRG Grouper logic in their data system. DHCF shall not provide DRG Grouper software to the Contractor.

The Contractor is not expected to edit the claims provided on the claim tapes to determine if the fiscal intermediary accurately assigned the correct DRG and/or DRG Grouper code edits. For those cases where miscoding or an inaccurate data elements leads to an erroneous DRG assignment that results in a higher –weighted reimbursement, the Contractor shall employ the following algorithm: (See Appendix 28)

- A “Notice of Proposed DRG Change” is sent to the facility. The facility is allowed thirty (30) days to submit additional information.

- If the facility agrees with the Contractor’s DRG change, a “Final Notice of DRG change: will be sent to the facility. Review results will be entered into the Contractor’s database for future reporting and recoupment by DHCF.

- If a response is not received from the facility, the original determination will be the final determination and a "Final Notice of DRG change" will be sent to the facility. Review results will be entered into the Contractor's database for future reporting and recoupment by DHCF.

- If the facility disagrees with the Contractor's proposed change, the case will be referred to a physician reviewer for a medical determination unless the change is a result of a coding principle.

- If the DRG change is a result of a coding principle, a Final Notice will be sent to the provider and the review results will be entered into the Contractor's database for future reporting and recoupment by DHCF.

- If the case is reviewed by a physician, and the physician upholds the Contractor's proposed DRG change, a Final Notice will be sent to the provider and the review results will be entered into the Contractor's database future reporting and recoupment by DHCF.

- If the physician review reverses the Contractor's proposed DRG change, a Final DRG letter of Agreement will be sent to the provider, the review results will be entered into the Contractor's database.

80.720 Procurement of Records

The Contractor shall request records for review, allowing sixty (60) days for the provider to respond. The Contractor may attempt such request twice within the sixty (60)-day period. Failure of the provider to respond to such request(s) shall result in establishing a recoupment and initiation of a preliminary findings letter for that amount.

80.730 DRG Reporting Requirements

80.731 Scope of Reporting Requirements

The Contractor shall review all records upon discharge.

80.732 Time Frame Reporting Requirements

Contractor shall provide reports as listed below to the Department on a quarterly basis by the 45th day following the close of the review period. If the Department requests more detailed information, Contractor shall provide it in a timely manner.

80.733 Required Data Elements of the Report

The Contractor on a quarterly basis will send a diskette, which will contain the completed DRG reviews. The data tale from the Contractor shall contain the following fields:

- Contractor ICN
- Provider ID
- Provider Name
- Provider city and State of Wisconsin
- EDS ICN
- Detail Line
- Recipient Name
- Admit Date
- Discharge Date
- Hospital DRG Billed and Relative Weight
- Billed amount
- Paid amount
- Audit Quarter
- Record index
- Deny reason/Description of Concern
- Claim cut back

80.734 Reports of Findings

The diskettes are to be accompanied by a concise written narrative noting:

1. An overview of the process used in review.
2. Significant findings of each review activity.
3. Problems encountered in performing the review.
4. Recommendations, if applicable, for modifications to the review process.
5. Suggested follow-up activity.
6. Recommendations for continued review in the areas reported on during the reporting period.
7. Coding change sequencing. (See Appendix 28 DRG flow sheet).

The Contractor will meet with the DHFC Nurse Contract Manager on a quarterly basis to discuss the DRG reviews.

Quarterly, the Contractor will submit a summary, which includes the name of the facility, the name of the recipient, and the admission date for all DRG records reviewed without findings.

If the Contractor identifies both findings (not medically necessary and incorrect DRG classification) during their review of a medical record, the reviewer shall recoup the larger amount.

If a medical record is denied for a utilization concern and also has a DRG change concern, all letters will be processed simultaneously. Therefore, if the utilization denial was over-turned at a reconsideration hearing, the DRG recoupment could still take place.

The Contractor will review all the rebuttal documentation the provider sends in and will return the information to the Bureau for the initiation of the Notice of Intent to Recover or closure of the review via the Surveillance Utilization Review (SUR).

80.740 Reports of Suspect Provider Altered Documents

The Contractor will report and send examples of suspected provider-altered documents to the Bureau contract manager. The provider should also discuss record review problems with the contract manager.

80.800 RECOUPMENT PROCESS

The Contractor shall assist DHCF in the process of recoupment of payments to non-HMO inpatient hospital admissions deemed to be not medically necessary or improperly billed. The process to be used by the Contractor and DHCF staff for pre-recoupment is outlined in Appendix 16.

80.900 INPATIENT HOSPITAL REVIEW REPORTING REQUIREMENTS

80.901 General Reporting Requirements

The Contractor shall provide reports for reviews completed during the report period, as well as accumulative totals to date for all Review of Admissions and Retrospective Reviews including Short Stays, Readmissions, and Referrals

All telephone and E-mail communications received from providers relative to the reviews identified in 80.000 - 80.700 are to be included in the reports. The chief medical officer and designated contract officer will receive the reports according to the following schedule:

Review Periods	Report Due Date
Quarterly: July 1 – September 30, 2003	November 15, 2004
October 1 – December 31, 2004	February 15, 2005
January 1 – March 31, 2004	August 15, 2005
April 1 – June 30, 2004	August 15, 2005
Annual: July 1, 2003 – June 30, 2004	August 15, 2005

All reports submitted by the Contractor are to be accompanied by a concise written narrative noting:

1. An overview of the process used in review.

2. Problems encountered in performing the review.

3. Significant findings of each review activity.

4. Recommendations, if applicable, for modifications to the review process.

5. Suggest follow-up activity.

6. Recommendations for continued review in the areas reported on during the reporting period.

80.910 Reports of Admission Review

Report 1: Admission Review Activity by Hospital
Report 2: LMR Denials by Hospital in Rank Order
Report 3: Utilization Denial Rates for Hospitals for 6-month Intervals
Report 4: DRG Change Report
Report 5: Utilization Denials Rates for Physicians for 3 Years

80.920 Quality of Care Screen Review

Report 6: Quality of Care Problems by Hospital
Report 7: Quality of Care Problems by Physician

80.930 Quarterly Workload Reports

1. Contracted review volume
2. Number of reviews initiated in quarter
3. Number of reviews completed in quarter
4. Total number of reviews completed year-to-date
5. Contract review balance (A - D)

80.940 Reporting Requirements for Behavioral Health

All behavior health reports shall be submitted to DHCF chief medical officer and designated contract monitor. The Contractor shall submit to DHCF on an annual basis workload reports of reviews by the 45th day following the close of the calendar quarter. Reports 11 and 12 shall include, at a minimum, information similar to that generated on the Medical/Surgical Preadmission and Retrospective Review Workload Reports. The reports are noted below:

Report 11: Preadmission Workload Report

Report 12: Retrospective Review Workload Report

Report 21: Inpatient Behavioral Health Telephonic Workload Report
This report shall include:
1. Total number of telephonic preadmission reviews
2. Total number of telephonic urgent/emergent reviews

Report 22: Inpatient Behavioral Health Retrospective Workload Report

This is a report of the total number of Behavior Health Retrospective reviews and shall include:

1. Number admitted to IMD (< 21 years old)
2. Number of AODA inpatient stays 0 - 2 days
3. Number of telephonic suspect admission cases

Report 31A: Behavioral Health Admission denials (Non-CON) by Hospital
This is the audit version of the Recoupment Report.

Report 31M: Behavioral Health Admission denials (Non-CON) by Hospital
This is the medical version Recoupment Report.

The Contractor shall provide the following reports as listed on an annual basis by the 45th day following the close of the calendar year. If the DHCF requests more detailed information, the Contractor shall provide it in a timely manner.

Report 23: Utilization Physician Denials by Reason in Rank Order

Report 24: Quality of Care Problems by Hospital

PART 3: CERTIFICATE OF NEED DOCUMENTATION REVIEW OF NON-HMO INPATIENT MENTAL HEALTH/SUBSTANCE ABUSE (MH/SA) HOSPITALIZATION

SECTION 90

90.000 MH/SA CERTIFICATE OF NEED DOCUMENTATION REVIEW

Objectives of the Mental Health/Substance Abuse (MH/SA) Certificate of Need (CON) documentation review, the review method, and reporting requirements are set forth in this part.

90.001 Review Objectives

The purpose of the MH/SA CON documentation review is to monitor the compliance of specialty hospitals to state and federal regulations relative to the hospitalization of Medicaid recipients under the age of twenty-one for treatment of mental health or substance abuse. Refer to Appendix 11 for a description of the Medicaid utilization review process. Refer to Appendix 24 for a description of the CON decision process.

90.002 Certificate of Need

The CON is required documentation for inpatient psychiatric services provided to individuals under the age of 21 at the time of hospitalization to support the medical necessity of services.

The CON contains the following information: recipient's first and last names, date of birth, date the certifying physician and other team members signed the form, signature and credentials of certifying physician and other team member(s).

90.003 Key Elements of a CON Review

The following information is noted on each CON form reviewed retrospectively: recipient's first and last name, date of birth, date the certifying physician and other team members signed the form, signature and credentials of certifying physician and other team member(s).

With the exception of the CON for individuals who do not have Medicaid upon admission, all other CON forms are completed within required timelines:

1. Non-emergency admissions must be signed and dated on or prior to the date of admission.

2. Emergency admissions must have a completed CON form signed and dated within fourteen (14) days of the admission date.

3. For individuals who apply for Medicaid while in the facility, the team responsible for the plan of care must sign CON forms. The team includes a physician and must cover any period before application for which claims are made.

90.100 CERTIFICATE OF NEED FOR NON-EMERGENCY ADMISSIONS

90.110 MH/SA Retrospective CON Review

When applicable, MH/SA retrospective review process shall determine that a valid CON document is included in the medical record of all Medicaid recipients under the age of 21 admitted to an inpatient psychiatric facility.

To be considered valid, the following 7 assertions must be written within the CON document for non-emergency admissions:

1. The team preparing and signing the CON must be an independent team composed of no less than two members where one member is a physician.

2. No member of the team has an employment or consultant relationship with the admitting facility.

3. The team must have competence in diagnosis and treatment of mental illness, preferably in child psychiatry.

4. Members of the team must have knowledge of the recipient's situation.

5. Ambulatory care resources available in the community do not meet the treatment needs of the recipient.

6. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.

7. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that services will no longer be needed.

90.120 Emergency Admissions CON Review

To be considered valid, the following 4 assertions must be written within the CON for emergency admissions:

1. The CON must be made within 2 weeks of admission by the team that meets the qualifications listed in 42 CFR 441.156.

2. Ambulatory care resources available in the community do not meet the treatment needs of the recipient.

3. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.

4. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that services will no longer be needed.

90.130 Application to Medicaid while Hospitalized CON Review

For individuals who do not have Medicaid upon admission, the team responsible for the plan of care must make the CON. The CON must cover any period before application for which claims are made, and have the following three assertions:

1. Ambulatory care resources available in the community do not meet the treatment needs of the recipient.

2. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.

3. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that services will no longer be needed.

90.104 Key Elements of a CON Review

The following information is noted on each CON form reviewed retrospectively: recipient's first and last name, date of birth, date the certifying physician and other team members signed the form, signature and credentials of certifying physician and other team member(s).

With the exception of the CON for individuals who do not have Medicaid upon admission, all other CON forms are completed within required timelines:

1. Non-emergency admissions must be signed and dated on or prior to the date of admission.

2. Emergency admissions must have a completed CON form signed and dated within fourteen (14) days of the admission date.

For individuals who apply for Medicaid while in the facility, the team responsible for the plan of care must sign CON forms. The team includes a physician and must cover any period before application for which claims are made.

90.200 CON REPORTING REQUIREMENTS

90.201 Scope of Reporting Requirements

The Contractor shall review all records upon discharge with the exception of records from specific hospitals named in section 90.207

90.202 Time Frame Reporting Requirements

The Contractor shall provide the reports listed below to the Department on a **quarterly basis** by the 45th day following the close of the review period. If the Department requests more detailed information, Contractor shall provide it in a timely manner.

90.203 Required Data Elements of the Report

The Contractor will send DHCF a diskette containing the completed CON reviews. The data table shall contain the following fields:

- Contractor ICN
- Provider ID
- Provider name
- Provider city, state
- EDS ICN
- Detail Line
- Recipient ID
- Recipient name
- Admit date
- Discharge date
- Billed amount
- Paid amount
- Audit quarter
- Record index
- Deny type
- Deny reason (identifies whether an admission was either not medically necessary or medically necessary in addition to the invalid CON finding)

90.204 Reports of Findings

If the Contractor identifies an invalid CON and/or no medical necessity during review of a medical record, the finding are placed on the CON diskette. A finding of invalid CON will take precedence over the finding of not medically necessary.

These *diskettes* are to be accompanied by a concise written narrative noting:

1. An overview of the process used in review.

2. Significant findings of each review activity.

3. Problems encountered in performing the review.

4. Recommendations, if applicable, for modifications to the review process.

5. Suggested follow-up activity.

6. Recommendations for continued review in the areas reported on during the reporting period.

   On a quarterly basis, the Contractor will submit a summary, which includes the name of the facility, the name of the recipient, and the admission date for all CON records reviewed without findings.

90.205 Reports of Suspect Provider-Altered Documents

The Contractor will report and send examples of suspected provider-altered documents to the Bureau contract manager. The provider may also discuss record review problems with the contract manger.

90.206 CON Reports

- Report 25: CON Compliance by Hospital
- Report 32A: Behavioral Health CON Denials by denial reason(s), Audit version
- Report 32M: Behavioral Health CON Denials by denial reason(s), Medical version

90.207 Exception to the CON Reporting Timeframe Requirements

The Contractor will review all records based on discharge date with the following exception:

- Winnebago
- Mendota
- Milwaukee County Mental Health Center.

These three hospitals tend to have lengthy inpatient hospital stays. The Contractor will review these CONs at the time the first interim bill is submitted. This will put the hospital on notice and give them the opportunity to find another payor source if the CON is denied. The Contractor will develop a process to ensure that the CON review of one recipient is not completed multiple times if there are several interim bills on different data tapes.

100.000 HEALTH MAINTENANCE ORGANIZATION QUALITY IMPROVEMENT ACTIVITIES

Quality improvement activities of Health Maintenance Organizations (HMOs) are set forth in this section.

These activities include the review of cases of physicians targeted for review, Care Analysis Projects (CAPs), Performance Improvement Projects (PIPs), and Encounter Data Validity Audits (DVAs). Review methods and reporting requirements are also described.

100.001 General Purpose of HMO Review Process

The goals of the Medicaid HMO program are to promote the cost-effective use of Medicaid services; provide quality health care to enrolled recipients; improve continuity of recipient care; encourage competition between cost effective providers; and enhance access to care by allowing recipients to choose among several health care providers.

Medicaid's current principal service areas of review are obstetrical, well baby, well child health care and adult health care. This is consistent with federal and state efforts, and is compatible with Wisconsin's Medicaid low-income families with children/BadgerCare population currently enrolled in HMOs.

The addition of BadgerCare to the programs brings with it a population that is significantly different from the low-income families with children/Healthy Start population. BadgerCare will contain families, so that young adult males will be a significant part of the BadgerCare program. Evaluation must include health care services that are important to this population, including but not restricted to Mental Health/Substance Abuse (MH/SA) services, emergency room use, acute hospitalizations, and high-cost services for selected chronic disease states.

100.002 Cases Selected for HMO Reviews

To select cases, the Contractor shall use an appropriate statistically valid random sample of a DHCF approved level of confidence and significance of recipient records for review for appropriateness and quality of care. Medicaid HMO cases will be selected for the following reviews:

- Case Review of enrollees who receive care from a physician who is the subject of a targeted review.

- Case Reviews selected for the Care Analysis Projects (CAPs) – as determined by the DHCF.

- Cases reviewed in the Performance Improvement Projects (PIPs) – as determined by the DHCF.

- Data from cases selected for the Encounter Data Validity Audit (DVA).

100.003 General Review Activities

DHCF will inform HMOs of long-range audit activity plans to enhance the HMO's resource allocation process. This can be accomplished by the HMO Quality Technical Advisory Committee (QTAC). The Department will notify providers prior to the beginning of the records acquisition process to prepare them for the audit, explain its goals, and the provider's obligation to cooperate with the process.

The HMO must assist the Contractor in the identification of providers and recipient information that is necessary to carry out activities necessary to perform data study evaluations and data validation. In addition, the HMO must assist the Contractor in obtaining information and data necessary to carry out the on-site or off-site medical chart reviews.

The Contractor will provide the HMOs the listing of records requested for the audit at the time the initial request for records is sent to providers. After providers respond to the initial records request, the Contractor will provide the HMO with a list of providers and records not obtained from providers after the initial records request. The HMOs will assist the Contractor with acquisition of requested records unless otherwise stipulated by the DHCF. The Contractor may be directed to go on-site to do the record review or copying for clinics that have a large Medicaid client base. General principles for reviews include:

- Topics identified by the audit reports as quality improvement opportunities may be used for baseline studies for performance improvement projects. If the topic is not one of the Targeted Performance Improvement Measures or Priority areas the topic must have the approval of the Department.

- Medical record review will be limited to the HMO enrollee span of enrollment.

- Whenever possible, small sample sizes will be utilized, facilitated by risk-stratification and targeted case review criteria.

- Whenever possible, audits will be scheduled so that records acquisition does not coincide with HMO record review activities for commercial HEDIS® reporting.

- The HMOs are to be informed of the planning process immediately prior to the initiation of the records acquisition phase to inform them of topics and medical record submission requirements.

- The Contractor will provide HMOs with a copy of any audit tools to be used and a description of the standards of care to be used in the audit, if applicable.

- The Contractor will provide the HMOs the listing of records requested for the audit at the time the initial request for records are sent to providers.

- The Contractor and representatives of the Department will meet with HMOs on overall report results to resolve general issues.

Timelines:

The Contractor performs initial record request/acquisition activity. The Contractor will have **45 calendar days** from the time they receive the sample listing from DHFS to complete the first record request contacts to the clinics. The HMO will assist in acquisition of records that are not provided after the first round request by the Contractor. Contractor must provide timely notice to the HMOs of any records not secured in the first attempt. The HMOs will have **45 calendar days** to acquire the missing records. NO extensions of time will be granted for either process. At the close of the HMO's 45 days, the Contractor will proceed with the audit with the records available.

- HMOs will get **30-90 calendar** day notice of the audit process so they can provide advance notice to clinics and plan resource allocation.

- The Contractor is to produce report to DHCF after record acquisition phase is deemed complete in **forty-five (45) calendar days**.

- DHCF evaluation of the Contractor report and subsequent report to HMOs will occur in **fifteen (15) working days.**

- Sixty (60) calendar day time frame for HMO QAPI committee response to report findings and for development or implementation of corrective actions, if required. The HMO must respond to serious adverse quality of care findings within **fifteen (15) working days.**

- Maximum start-to-finish audit time goal is **ten (10) calendar months** (305-310 days) for each review cycle.

100.004 Orientation meeting for physician office staff

The Contractor is responsible for arranging orientation meetings for physician office staff concerning medical chart review and data analysis, and encouraging attendance at these meetings by HMO and physician office staff as necessary.

100.005 Review Objectives

The purpose of this review is to assure that the care provided to Wisconsin Medicaid recipients enrolled in HMOs is complete, timely, necessary, appropriate and consistent with generally accepted standards of care. The data validity audit will provide the DHCF with a measure of the completeness and accuracy of HMO submitted encounter data.

100.100 REVIEWS

100.101 Focused Provider Review

The enrollees who received services from a physician who is the subject of a focused review shall be identified, for example, from the peer review body's (the Contractor) previous reviews. All enrollees who received services from the targeted physician shall have their charts reviewed for those services.

100.102 Performance Improvement Project (PIP) Review

At least two performance improvement projects, selected by the HMOs, will be made available to DHCF by October 1st of each year. The database for selection of the performance improvement projects shall be HMO self-reported data, or other appropriate database. Subsequent performance improvement project areas may be selected by the DHCF and shall depend on population relevance, data and information available to the DHCF and the HMO (survey data, prior performance improvement projects previously submitted by HMOs, etc.), and public interest or HMO concern about a particular area. The Contractor shall provide an evaluation of each performance improvement project and a written critique of the project to the DHCF within ninety (90) days of receipt of the study from the DHCF. Criteria for review include but are not limited to those listed in Addendum XV of the HMO contract (Appendix 22).

100.103 Medical Record Quality of Care Review Process

Medical record quality of care reviews will be performed on all cases selected for review.

The Contractor's HMO QI medical record reviews shall be conducted through either on-site visits at the physician's office or off-site desk reviews at Contractor's premises. Every case selected for review, for any reason, shall undergo quality of care review, using appropriate Wisconsin Medicaid program approved quality screens (Appendix 20). Cases with possible quality of care problems, in the judgment of nurse reviewers, shall be referred to the Contractor's physician reviewer for review. (The process for handling quality of care concerns is outlined in Appendix 18)

Confirmed quality of care cases shall be forwarded to DHCF chief medical officer and designated contract monitor as outlined in Appendix 18. In each recipient case where

questionable quality of care is noted, the Contractor shall provide the DHCF and identified HMO with a narrative written report of the questionable case(s). The narrative report shall discuss in detail and clearly identify the specifics (date, questionable practice, criteria failed, physician, setting, etc.) of the questionable quality of care delivered or not provided. Each HMO shall receive reports concerning the potential quality of care cases pertaining to Medicaid recipients identified in their HMO only.

Where Contractor's review determines the occurrence of medical mismanagement with significant adverse effects on the patient, copies of the entire Contractor's review file on the case, including copies of medical records used in the review process, shall be sent to the DHCF chief medical officer immediately after discovery.

An individual HMO case may require that the Contractor review the HMO enrollee's ambulatory care medical record and hospital records. The Contractor shall request the hospital records in accordance with the procedures used for the Non-HMO Medical Review Activity in Section 80.

100.200 QUALITY OF CARE REVIEW CRITERIA

The following criteria shall be used by the Contractor to assess the quality of care provided to HMO enrollees with appropriate modification for reporting results.

Medicaid HMO Quality Review Criteria are as follows:

- Medicaid Health Condition Review Criteria.
- Medicaid Generic Review Criteria.

100.300 PERFORMANCE IMPROVEMENT PROJECT REVIEW

At least two performance improvement projects in a clinical or non-clinical area are required by each HMO on an annual basis. In addition, one performance improvement project in a non-clinical area is required on an annual basis. The Contractor shall evaluate the performance improvement projects submitted by the HMOs for accuracy, relevance and quality. Refer to Appendix 22 for the current evaluation instrument. The Contractor shall be responsible for evaluation of the study design for the performance improvement projects. Evaluation of the studies must be completed within ninety (90) days after the DHCF provides the Contractor with the performance improvement project reports. Choice of the HMOs' performance improvement project for review shall be made in accordance with **ARTICLE III (III) FUNCTIONS AND DUTIES OF THE HMO** W (13) of the contract for Medicaid/BadgerCare HMO services, and shall depend on the quality of the performance improvement projects from previous years, whether the HMO has NCQA/other accreditation, whether HMO has addressed significant problems and developed a workable follow-up plan.

100.400 DATA VALIDATION STUDY

HMOs selected for a data validation study shall be identified by DHCF and reported to the Contractor on an annual basis, but will consist of no more than one half of the number of participating HMOs during the reporting period. HMOs may be randomly or non-randomly selected by DHCF for inclusion in the DVA. The criteria for non-random selection includes but is not limited to:

- Selection based upon the number and importance of data elements that are outliers,
- Selection based on the importance of those indicators to quality,
- Selection based upon the quality of previous data submissions,
- Selection based on results from previous data validity studies,
- Selected due to past participation of the HMO with Medicaid managed care data submissions, and
- Selected as a result of other information about the HMO available to the DHCF.

The indicators for data validity audit review shall consist of three (3) review areas for each review period, as determined by the DHCF. Selection of targeted HMOs and the specific data validity concerns of the DHCF shall be made available to the Contractor.

Data subjected to data validation shall consist of statistically valid samples of:

- Positive Pap sample = enrollees the HMO reported as having had a pap test during the reporting period.
- Negative Pap sample = enrollees the HMO reported as not having a pap test during the reporting period.

For other encounters, a “Positive Reporting Sample” of enrollees will be selected and their medical records are reviewed against specified encounters. This will determine whether all encounter data has been submitted for services that were delivered. These encounters include but are not limited to:

- Random or targeted services,
- Selected encounter data elements,
- Procedure codes, and
- Other encounter data validity concerns of the DHCF.

For other encounters, a "Negative Reporting Sample" of enrollees will be selected and their medical records reviewed against specified encounters. This will determine whether all encounters not having been delivered were indeed not delivered. Selection of the records for review of encounters not delivered will be done randomly or selected due to the presence of certain encounter data elements, procedure codes, or other encounter data validity concern of the DHCF regarding a particular, or all, HMOs, were not reported as delivered services.

The Contractor shall design the validity study and the DHCF chief medical officer shall approve it prior to the audit. Validity study designs will be individualized to address the data validity issues identified by the DHCF.

The Contractor shall use an appropriate statistically valid random sample to achieve a DHCF approved level of confidence and significance for the indicators selected in the data validity review of medical records (Data Validity Audit Part II). Refer to Appendix 21 for the potential number of reviews.

The DHCF shall approve the preliminary report of the DVA on a timely basis. Upon completion of the DHCF review of the DVA, the Contractor must provide a final report to the DHCF for each selected HMO outlining the conclusions of the study and make recommendations for corrective actions, if any. At a minimum, the DVA report shall:

- Describe the data validity problems.
- Briefly describe the causes of the data submission errors.
- Suggest and/or describe possible corrective actions.
- Recommend a follow up plan to monitor the response to the suggested corrective action plan.

100.500 REPORTING REQUIREMENTS

Annual reports – initial reports are due as appropriate according to the time line of the particular review activity.

Report 1: Performance Improvement Project Review – by HMO

Report 2: By HMO:
- Targeted Physician Services Review
- Focused Provider Review
- Quality of Care Review

Report 3: Encounter Data Validation Study – Data specific to each HMO

Report 4: Summary report of all HMOs for:
- Performance Improvement Project Evaluation Review
- Encounter Data Validation Study

All written reports, unless otherwise specified by the DHCF, will for the individual HMO contain an executive summary and a detail report. Where there are multiple HMOs being reported there will be an overall summary report describing the findings for HMOs.

PART 3: FEE FOR SERVICE (FFS) AMBULATORY QUALITY IMPROVEMENT REVIEW

SECTION 110

110.000 OVERVIEW OF FFS AMBULATORY REVIEW PROCESS

The Fee for Service (FFS) Ambulatory Review Process includes Medicaid eligible recipients not enrolled in an HMO and is similar to the HMO quality improvement review process are contained in this part.

110.100 FFS AMBULATORY RETROSPECTIVE MEDICAL RECORD REVIEW PROCESS

110.110 Retrospective Review

110.111 Review Objective

The purpose of the retrospective review is to assure that the ambulatory care provided to non-HMO Medicaid recipients is complete, timely, medically necessary, appropriate, and consistent with generally accepted standards of care.

110.112 Scope of Review

The Contractor shall use an appropriate statistically valid random sample of a DHCF approved level of confidence and significance of recipient records for review for appropriateness and quality of care. Refer to Appendix 21 for the potential number of reviews.

110.120 Focused Review of Provider

The enrollees who received services from a physician who is the subject of a DHCF focused review shall be identified from the fiscal intermediary paid claims data. All enrollees who received services shall have their charts reviewed for appropriateness, medical necessity and quality of all services received from the provider who is being reviewed.

110.130 Chronic Conditions Review

The Contractor will select a random sample of non-HMO Medicaid recipients who have chronic conditions. The database shall be paid claims data of the fiscal agent. The Contractor shall review selected cases for appropriateness and quality of care. The Contractor shall develop appropriate review instruments for selected reviews and the instrumentation must be approved by DHCF. Review of services for enrollees with selected diagnoses for chronic disease states include:

1. Mental health disorders

2. Substance abuse

The category of cases selected for review may change at the discretion of the DHCF.

110.140 Targeted Physician Services Review

The database for the targeted physician services review shall be from the fiscal intermediary paid claims data. The Contractor shall use appropriate statistical methods to select a random sample of recipient records for review for appropriateness and quality of care. The Contractor shall develop and use DHCF approved review instruments.

110.141 Review Scope

The scope of this review is to be determined by DHCF. For selected procedures, DHCF will select the scope upon review and advisement by a subcontractor.

110.150 Random Sample of Ambulatory Surgical Cases

The Contractor shall select a random sample of ambulatory surgical cases for review for appropriateness, medical necessity and quality of care.

110.151 Review Scope

The scope of this review will be selected procedures as determined by the Division of Health Care Financing using Contractor data analysis.

110.200 REVIEW PROCESS

The Contractor shall select an appropriate sample for each of the review areas from the claims paid database of the fiscal agent. The review will utilize the appropriate screening or review instrument and shall include a quality of care review. Refer to Appendix 18 for a description of the quality review process. All reviews will be performed as determined by the DHCF; it is not necessary that the reviews have the same beginning/end date.

110.300 REPORTING REQUIREMENTS

The reports shall include an analysis of the data to include how successfully program requirements were met; concerns about access (structural and administrative) that may play a role in producing the documented outcome for each non-HMO provider reviewed. The report shall include recommendations for improving the ability of non-HMO providers to meet program thresholds, and shall include recommendations regarding follow-up in the specific review area(s).

The Contractor shall prepare a report for the DHCF which summarizes findings in each review area for all participating non-HMO providers reviewed.

Reports are due forty-five (45) days following the close of the first contract year, and annually thereafter.

Annual reports shall include:

Report 1: By individual non-HMO provider reviewed
Targeted Physician Services Review

Report 2: Summary report of non-HMO activity of all non-HMO Providers reviewed
Chronic Condition Review
Targeted Physician Services Review

Report 3: Summary report of ambulatory surgical cases by facility

Report 4: Summary report of ambulatory surgical cases by provider

120.000 OVERVIEW OF WISCONSIN SMCOS

The Department of Health Care Finances (DHCF) has implemented special managed care programs for recipients with chronic, and/or complex health care needs. The programs are designed to provide quality health care services with the most efficient use of resources. Enrollment in any of the special managed care programs is voluntary.

The special managed care programs have individually implemented QI strategies, and are required to submit Utilization Review (UR) and Quality Improvement (QI) reports to the DHCF.

120.001 Common Goals of the SMCOs

1. To enable special managed care populations including people with chronic illnesses, SED, mental illness, frail elderly, and disabled to live in community based settings.

2. To achieve optimal long term care and health outcomes among enrollees.

3. To assure that enrollees have access to comprehensive care.

4. To provide care that is integrated and continuous across systems and service types.

5. To achieve a high level of enrollee satisfaction.

6. To assure that enrollees have sufficient information to make informed choices and to respect those choices.

120.002 Purpose of the Review Process

The purposes of the Contractor review are:

1. To validate data and information including performance measures submitted by the SMCOs to the DHCF for the purpose of quality assessment.

2. To validate SMCO Performance Improvement Projects (PIPs) to ensure that PIPs are designed, conducted and reported in a methodologically sound manner.

Validation may include the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

3. To review compliance with structural and operation standards established by the state.

4. To provide DHCF and the programs with information about their performance that is not available from other sources of data.

5. To provide information that will aid DHCF and the programs in interpreting other sources of data, such as encounter data.

6. To provide insight and information about factors that influenced differences in program performance among similar populations.

7. To provide information that is useful to programs for their ongoing quality improvement processes.

8. To provide information that will be useful to DHCF in fulfilling its oversight role for developing the SMCO's contract requirements.

120.003 Department Oversight of Contractor Activities

The Contractor is accountable to DHCF staff who administer the Special Managed Care Programs as needed to:

1. Develop and define the scope of work for Contractor review.

2. Conditions to be met by the Contractor in conducting the review.

3. The criteria for the review, the issues or cases to be targeted.

4. The elements to be included in final product.

120.004 Review Conditions

To perform a review compatible with the purposes identified in 120.01, the Contractor must:

1. Have an understanding of each individual SMCO program including the scope of contract requirements and the special populations served.

2. Have an understanding of Wisconsin and federal regulations that impact the SMCOs (e.g., regulations regarding the scope of practice of nurse practitioners).

3. Have the ability to work collaboratively with DHCF staff who administer the Special Managed Care programs.

4. Have the ability to work collaboratively with SMCOs administrators and medical directors, especially in developing relevant review criteria.

5. Be able to provide staff for this project that have sufficient expertise in the area of long term managed care.

6. Be able to provide staff for this project who have an understanding of the unique characteristics and needs of the long term care population including people with disabilities and the frail elderly.

120.005 Topic Selections for On-site Reviews

The Contractor will review topics selected by the DHCF administrative staff. Topics will be selected following an analysis of claims/encounter data, survey data and other information supplied to the Department from the programs. Criteria used to choose topics for review include, but are not limited to:

1. The review area will be consistent with Federal requirements. See Appendix 27 – EQRO Mandatory Protocols.

2. The significant variation in outcomes existing among programs for matched enrollees (e.g., nursing home admission rate varies widely among matched enrollees).

3. The frequency of events or conditions that occur in SMCO populations.

4. The management of cases or conditions that have the potential for morbidity or unexpected mortality.

The percentage of cases reviewed for each program may vary depending on the criteria applied for case selection.

120.100 ON-SITE REVIEWS

The Contractor will be asked to go to the SMCO on-site to assess elements of care and care management that may have contributed to positive and/or negative outcomes.

120.101 Focus of Reviews

The Contractor will be asked to focus their reviews on elements of care that are consistent with SMCOs program goals and required scope of services. Specifically, focus of Contractor reviews will be evaluate whether:

1. Access to services or care contributed in a positive or negative way to an outcome. Access to services or care is defined as the availability and appropriateness of care in a timely manner.

2. Continuity and integration of care contributed in a positive or negative way to an outcome. Continuity and integration of care is defined as avoiding gaps or delays in services through optimal communication and completeness of information required for decision-making and the receipt of important services.

3. Comprehensiveness of care contributed in a positive or negative way to an outcome. Comprehensiveness of care is defined as having a provider network of sufficient scope and size and is capable of delivering the full range of services required by SMCOs goals and contracts.

4. Health and Long term care preventive measures contributed in a positive or negative way to the outcome. Preventive measures are defined as services, tests and recommendations which, if performed or made, might have resulted in a positive outcome or helped avoid a negative outcome.

5. Enrollee choices contributed in a positive or negative way to an outcome. Enrollee choices are defined as decisions about lifestyle, compliance with care recommendations, and risks that may have influenced an outcome.

120.102 Methods for Review

The Contractor is expected to use a variety of methods to obtain information for their review. The methods used may vary depending on the nature of the cases reviewed and the type of focus areas (120.400) that are relevant to the review. The methods of review may include, but not be limited to:

1. Review of service delivery and/or care management records.

2. Interviews or surveys of care manager and/or care team members

3. Interview with SMCO administrative staff.

4. Interviews or surveys of providers that contract with SMCOs.

5. Interviews or surveys of members.

6. Review of policies, procedures, and systems to assure compatibility with State and Federal requirements.

120.103 Review Process

1. Data submitted by the SMCOs will be analyzed by the DHCF staff.

2. DHCF criteria for topic selection (120.300) will be applied to the data.

3. DHCF administrative staff in collaboration with the programs will determine the review focus.

4. Methods for the review (120.400) for the reviews will be determined by DHCF staff and communicated to the SMCOs.

5. The Contractor will conduct a preliminary analysis of the data collected during the reviews and present the data and analysis to DHCF staff.

6. The Contractor will submit a draft report to DHCF describing their findings.

7. The draft report will be sent to the SMCOs for comment.

8. The DHCF and DDES will review the comments of the programs.

9. DHCF and DDES will issue a final report.

10. If appropriate, the programs will submit a corrective action plan for review and oversight by DHCF and DDES.

120.200 PERFORMANCE IMPROVEMENT PROJECT EVALUATION REVIEW

Depending upon the SMCO, one or two focused quality performance improvement project(s) are required annually for the special managed care program. These studies are due for submission to the DHCF by October 1st of each year. The Contractor shall evaluate the performance improvement projects for accuracy, relevance and quality. The Contractor shall be responsible for evaluation of the study design for the priority areas. Evaluation of the studies must be completed within ninety (90) days after the DHCF provides the Contractor with the studies.

120.201 Performance Improvement Project Review Process

The Contractor shall evaluate the performance improvement projects conducted by the special managed care programs and provide a report to the DHCF. The Contractor shall evaluate the performance improvement projects for choice of topic, study goals and indicators, criteria for determining if performance met the indicators, sample selection, sample size, data sources and collection methodology, data analysis plan, data analysis, presentation and interpretation, improvement plan, re-evaluation, and distribution of results to providers.

The Contractor shall assess the following details of the study to answer the ten questions developed by the DHCF. Refer to Appendix 23 for the ten questions.

120.300 REPORTS

All written reports, unless otherwise specified by the DHCF, will for the individual special managed care program contain an executive summary and a detail report. Where there are multiple programs being reported there will be an overall summary report describing the findings for the programs.

Report 1: On-site Review Reports (120.100) include:

Report 2: Performance Improvement Project Reports (120.200) include:

- An evaluation of the PIPs submitted by each individual SMCO
- An executive summary for grouped SMCOs when appropriate.

Report 3: Institution Admission Reports include:
A summary of the acute care services used with a break down by special managed care program, by recipient and by admission diagnosis code (ICD.9.CM)

- By Managed Care Program
- By Recipient
- By Diagnosis

Report 4: Assessment and Plan of Care Review Report includes:

An analysis of the findings and recommendations to program improvement and monitoring procedures.

WISCONSIN MEDICAID

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APPENDICES

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APPENDIX: 1

DESIGNATION OF CONFIDENTIAL AND PROPRIETARY INFORMATION (DOA - 3027)

STATE OF WISCONSIN
DOA-3027 N(R01/98)

DESIGNATION OF CONFIDENTIAL AND PROPRIETARY INFORMATION

The attached material submitted in response to Bid/Proposal #0423-DHCF-SM_____ includes proprietary and confidential information which qualifies as a trade secret, as provided in s. 19.36(5), Wis. Stats., or is otherwise material that can be kept confidential under the Wisconsin Open Records Law. As such, we ask that certain pages, as indicated below, of this bid/proposal response be treated as confidential material and not be released without our written approval.

Prices always become public information when bids/proposals are opened, and therefore cannot be kept confidential.

Other information cannot be kept confidential unless it is a trade secret. Trade secret is defined in s. 134.90(1)(c), Wis. Stats. as follows: "Trade secret" means information, including a formula, pattern, compilation, program, device, method, technique or process to which all of the following apply:

1. The information derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use.
2. The information is the subject of efforts to maintain its secrecy that are reasonable under the circumstances.

We request that the following pages not be released.

Section	Page #	Topic

IN THE EVENT THE DESIGNATION OF CONFIDENTIALITY OF THIS INFORMATION IS CHALLENGED, THE UNDERSIGNED HEREBY AGREES TO PROVIDE LEGAL COUNSEL OR OTHER NECESSARY ASSISTANCE TO DEFEND THE DESIGNATION OF CONFIDENTIALITY AND AGREES TO HOLD THE STATE HARMLESS FOR ANY COSTS OR DAMAGES ARISING OUT OF THE STATE'S AGREEING TO WITHHOLD THE MATERIALS.

Failure to include this form in the bid/proposal response may mean that all information provided as part of the bid/proposal response will be open to examination and copying. The state considers other markings of confidential in the bid/proposal document to be insufficient. The undersigned agrees to hold the state harmless for any damages arising out of the release of any materials unless they are specifically identified above.

Company Name_____

Authorized Representative_____
Signature

Authorized Representative_____
Type or Print

Date_____

This document can be made available in accessible formats to qualified individuals with disabilities.

APPENDIX: 2

RFB COVER PAGE
(DOA - 3070)

WISCONSIN MEDICAID

APPENDIX 2

State of Wisconsin
DOA-3070 (R08/2003)
Wis. Statutes s.16.75

BIDS MUST BE SEALED AND ADDRESSED TO:

☐ Remove from bidder list for this commodity/service.
(Return this page only.)

AGENCY ADDRESS:

REQUEST FOR BID

THIS IS NOT AN ORDER

BIDDER (Name and Address)

Bid envelope must be sealed and plainly marked in lower corner with due date and Request for Bid # _____. Late bids will be rejected. Bids MUST be date and time stamped by the soliciting purchasing office on or before the date and time that the bid is due. Bids dated and time stamped in another office will be rejected. Receipt of a bid by the mail system does not constitute receipt of a bid by the purchasing office. Any bid which is inadvertently opened as a result of not being properly and clearly marked is subject to rejection. Bids must be submitted separately, i.e., not included with sample packages or other bids. Bid openings are public unless otherwise specified. Records will be available for public inspection after issuance of the notice of intent to award or the award of the contract. Bidder shall contact person named below for an appointment to view the bid record. Bids shall be firm for acceptance for sixty (60) days from date of bid opening, unless otherwise noted. The attached terms and conditions apply to any subsequent award.

Bids MUST be in this office no later than

Name (Contact for further information)

Phone Date

Quote Price and Delivery FOB

☐ Fax bids are accepted ☐ Fax bids are not accepted

Item No.	Quantity and Unit	Description	Price Per Unit	Total

Payment Terms	Delivery Time

☐ We claim minority bidder preference [Wis. Stats. s. 16.75(3m)]. Under Wisconsin Statutes, a 5 percent preference may be granted to CERTIFIED Minority Business Enterprises. Bidder must be certified by the Wisconsin Department of Commerce. If you have questions concerning the certification process, contact the Wisconsin Department of Commerce, 5th Floor, 201 W. Washington Ave., Madison, Wisconsin 53702, (608) 267-9550. **Does Not Apply to Printing Bids**.

☐ We are a work center qualified under Wis. Stats. s. 16.752. Questions concerning the qualification process should be addressed to the Work Center Program, State Bureau of Procurement, 6th Floor, 101 E. Wilson St., Madison, Wisconsin 53702, (608) 266-2605.

Wis. Stats. s. 16.754 directs the state to purchase materials which are manufactured to the greatest extent in the United States when all other factors are substantially equal. Materials covered in our bid were manufactured in whole or in substantial part within the United States, or the majority of the component parts thereof were manufactured in whole or in substantial part in the United States.

☐ Yes ☐ No ☐ Unknown

In signing this bid we also certify that we have not, either directly or indirectly, entered into any agreement or participated in any collusion or otherwise taken any action in restraint of free competition; that no attempt has been made to induce any other person or firm to submit or not to submit a bid; that this bid has been independently arrived at without collusion with any other bidder, competitor or potential competitor; that this bid has not been knowingly disclosed prior to the opening of bids to any other bidder or competitor; that the above statement is accurate under penalty of perjury.

We will comply with all terms, conditions and specifications required by the state in this Request for Bid and all terms of our bid.

Name of Authorized Company Representative (Type or Print)	Title		Phone ( ) Fax ( )
Signature of Above	Date	Federal Employer Identification No.	Social Security No. if Sole Proprietor (Voluntary)

This form can be made available in accessible formats upon request to qualified individuals with disabilities.

APPENDIX: 3

STANDARD TERMS AND CONDITIONS
(DOA - 3054)

Wisconsin Department of Administration
Chs. 16, 19, 51
DOA-3054 (R01/2001)
Page 1 of 4

STANDARD TERMS AND CONDITIONS
(REQUEST FOR BIDS/PROPOSALS)

1.0 **SPECIFICATIONS:** The specifications in this request are the minimum acceptable. When specific manufacturer and model numbers are used, they are to establish a design, type of construction, quality, functional capability and/or performance level desired. When alternates are bid/proposed, they must be identified by manufacturer, stock number, and such other information necessary to establish equivalency. The State of Wisconsin shall be the sole judge of equivalency. Bidders/proposers are cautioned to avoid bidding alternates to the specifications which may result in rejection of their bid/proposal.

2.0 **DEVIATIONS AND EXCEPTIONS:** Deviations and exceptions from original text, terms, conditions, or specifications shall be described fully, on the bidder's/proposer's letterhead, signed, and attached to the request. In the absence of such statement, the bid/proposal shall be accepted as in strict compliance with all terms, conditions, and specifications and the bidders/proposers shall be held liable.

3.0 **QUALITY:** Unless otherwise indicated in the request, all material shall be first quality. Items which are used, demonstrators, obsolete, seconds, or which have been discontinued are unacceptable without prior written approval by the State of Wisconsin.

4.0 **QUANTITIES:** The quantities shown on this request are based on estimated needs. The state reserves the right to increase or decrease quantities to meet actual needs.

5.0 **DELIVERY:** Deliveries shall be F.O.B. destination freight prepaid and included unless otherwise specified.

6.0 **PRICING AND DISCOUNT:** The State of Wisconsin qualifies for governmental discounts and its educational institutions also qualify for educational discounts. Unit prices shall reflect these discounts.

6.1 Unit prices shown on the bid/proposal or contract shall be the price per unit of sale (e.g., gal., cs., doz., ea.) as stated on the request or contract. For any given item, the quantity multiplied by the unit price shall establish the extended price, the unit price shall govern in the bid/proposal evaluation and contract administration.

6.2 Prices established in continuing agreements and term contracts may be lowered due to general market conditions, but prices shall not be subject to increase for ninety (90) calendar days from the date of award. Any increase proposed shall be submitted to the contracting agency thirty (30) calendar days before the proposed effective date of the price increase, and shall be limited to fully documented cost increases to the Contractor which are demonstrated to be industrywide. The conditions under which price increases may be granted shall be expressed in bid/proposal documents and contracts or agreements.

6.3 In determination of award, discounts for early payment will only be considered when all other conditions are equal and when payment terms allow at least fifteen (15) days, providing the discount terms are deemed favorable. All payment terms must allow the option of net thirty (30).

7.0 **UNFAIR SALES ACT:** Prices quoted to the State of Wisconsin are not governed by the Unfair Sales Act.

8.0 **ACCEPTANCE-REJECTION:** The State of Wisconsin reserves the right to accept or reject any or all bids/proposals, to waive any technicality in any bid/proposal submitted, and to accept any part of a bid/proposal as deemed to be in the best interests of the State of Wisconsin.

Bids/proposals MUST be date and time stamped by the soliciting purchasing office on or before the date and time that the bid/proposal is due. Bids/proposals date and time stamped in another office will be rejected. Receipt of a bid/proposal by the mail system does not constitute receipt of a bid/proposal by the purchasing office.

9.0 **METHOD OF AWARD:** Award shall be made to the lowest responsible, responsive bidder unless otherwise specified.

10.0 **ORDERING:** Purchase orders or releases via purchasing cards shall be placed directly to the Contractor by an authorized agency. No other purchase orders are authorized.

11.0 PAYMENT TERMS AND INVOICING: The State of Wisconsin normally will pay properly submitted vendor invoices within thirty (30) days of receipt providing goods and/or services have been delivered, installed (if required), and accepted as specified.

Invoices presented for payment must be submitted in accordance with instructions contained on the purchase order including reference to purchase order number and submittal to the correct address for processing.

A good faith dispute creates an exception to prompt payment.

12.0 TAXES: The State of Wisconsin and its agencies are exempt from payment of all federal tax and Wisconsin state and local taxes on its purchases except Wisconsin excise taxes as described below.

The State of Wisconsin, including all its agencies, is required to pay the Wisconsin excise or occupation tax on its purchase of beer, liquor, wine, cigarettes, tobacco products, motor vehicle fuel and general aviation fuel. However, it is exempt from payment of Wisconsin sales or use tax on its purchases. The State of Wisconsin may be subject to other states' taxes on its purchases in that state depending on the laws of that state. Contractors performing construction activities are required to pay state use tax on the cost of materials.

13.0 GUARANTEED DELIVERY: Failure of the Contractor to adhere to delivery schedules as specified or to promptly replace rejected materials shall render the Contractor liable for all costs in excess of the contract price when alternate procurement is necessary. Excess costs shall include the administrative costs.

14.0 ENTIRE AGREEMENT: These Standard Terms and Conditions shall apply to any contract or order awarded as a result of this request except where special requirements are stated elsewhere in the request; in such cases, the special requirements shall apply. Further, the written contract and/or order with referenced parts and attachments shall constitute the entire agreement and no other terms and conditions in any document, acceptance, or acknowledgment shall be effective or binding unless expressly agreed to in writing by the contracting authority.

15.0 APPLICABLE LAW: This contract shall be governed under the laws of the State of Wisconsin. The Contractor shall at all times comply with and observe all federal and state laws, local laws, ordinances, and regulations which are in effect during the period of this contract and which in any manner affect the work or its conduct. The State of Wisconsin reserves the right to cancel any contract with a federally debarred Contractor or a Contractor which is presently identified on the list of parties excluded from federal procurement and non-procurement contracts.

16.0 ANTITRUST ASSIGNMENT: The Contractor and the State of Wisconsin recognize that in actual economic practice, overcharges resulting from antitrust violations are in fact usually borne by the State of Wisconsin (purchaser). Therefore, the Contractor hereby assigns to the State of Wisconsin any and all claims for such overcharges as to goods, materials or services purchased in connection with this contract.

17.0 ASSIGNMENT: No right or duty in whole or in part of the Contractor under this contract may be assigned or delegated without the prior written consent of the State of Wisconsin.

18.0 WORK CENTER CRITERIA: A work center must be certified under s. 16.752, Wis. Stats., and must ensure that when engaged in the production of materials, supplies or equipment or the performance of contractual services, not less than seventy-five percent (75%) of the total hours of direct labor are performed by severely handicapped individuals.

19.0 NONDISCRIMINATION/AFFIRMATIVE ACTION: In connection with the performance of work under this contract, the Contractor agrees not to discriminate against any employe or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in s. 51.01(5), Wis. Stats., sexual orientation as defined in s. 111.32(13m), Wis. Stats., or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. Except with respect to sexual orientation, the Contractor further agrees to take affirmative action to ensure equal employment opportunities.

19.1 Contracts estimated to be over twenty-five thousand dollars ($25,000) require the submission of a written affirmative action plan by the Contractor. An exemption occurs from this requirement if the Contractor has a workforce of less than twenty-five (25) employes. Within fifteen (15) working days after the contract is awarded, the Contractor must submit the plan to the contracting state agency for approval. Instructions on preparing the plan and technical assistance regarding this clause are available from the contracting state agency.

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19.2 The Contractor agrees to post in conspicuous places, available for employes and applicants for employment, a notice to be provided by the contracting state agency that sets forth the provisions of the State of Wisconsin's nondiscrimination law.

19.3 Failure to comply with the conditions of this clause may result in the Contractor's becoming declared an "ineligible" Contractor, termination of the contract, or withholding of payment.

20.0 PATENT INFRINGEMENT: The Contractor selling to the State of Wisconsin the articles described herein guarantees the articles were manufactured or produced in accordance with applicable federal labor laws. Further, that the sale or use of the articles described herein will not infringe any United States patent. The Contractor covenants that it will at its own expense defend every suit which shall be brought against the State of Wisconsin (provided that such Contractor is promptly notified of such suit, and all papers therein are delivered to it) for any alleged infringement of any patent by reason of the sale or use of such articles, and agrees that it will pay all costs, damages, and profits recoverable in any such suit.

21.0 SAFETY REQUIREMENTS: All materials, equipment, and supplies provided to the State of Wisconsin must comply fully with all safety requirements as set forth by the Wisconsin Administrative Code, the Rules of the Industrial Commission on Safety, and all applicable OSHA Standards.

22.0 WARRANTY: Unless otherwise specifically stated by the bidder/proposer, equipment purchased as a result of this request shall be warranted against defects by the bidder/proposer for one (1) year from date of receipt. The equipment manufacturer's standard warranty shall apply as a minimum and must be honored by the Contractor. The time limitation in this paragraph does not apply to the warranty provided in paragraph 33.0.

23.0 INSURANCE RESPONSIBILITY: The Contractor performing services for the State of Wisconsin shall:

23.1 Maintain worker's compensation insurance as required by Wisconsin Statutes, for all employes engaged in the work.

23.2 Maintain commercial liability, bodily injury and property damage insurance against any claim(s) which might occur in carrying out this agreement/contract. Minimum coverage shall be one million dollars ($1,000,000) liability for bodily injury and property damage including products liability and completed operations. Provide motor vehicle insurance for all owned, non-owned and hired vehicles that are used in carrying out this contract. Minimum coverage shall be one million dollars ($1,000,000) per occurrence combined single limit for automobile liability and property damage.

23.3 The state reserves the right to require higher or lower limits where warranted.

24.0 CANCELLATION: The State of Wisconsin reserves the right to cancel any contract in whole or in part without penalty due to nonappropriation of funds or for failure of the Contractor to comply with terms, conditions, and specifications of this contract.

25.0 VENDOR TAX DELINQUENCY: Vendors who have a delinquent Wisconsin tax liability may have their payments offset by the State of Wisconsin.

26.0 PUBLIC RECORDS ACCESS: It is the intention of the state to maintain an open and public process in the solicitation, submission, review, and approval of procurement activities.

Bid/proposal openings are public unless otherwise specified. Records may not be available for public inspection prior to issuance of the notice of intent to award or the award of the contract.

27.0 PROPRIETARY INFORMATION: Any restrictions on the use of data contained within a request, must be clearly stated in the bid/proposal itself. Proprietary information submitted in response to a request will be handled in accordance with applicable State of Wisconsin procurement regulations and the Wisconsin open records law. Proprietary restrictions normally are not accepted. However, when accepted, it is the vendor's responsibility to defend the determination in the event of an appeal or litigation.

27.1 Data contained in a bid/proposal, all documentation provided therein, and innovations developed as a result of the contracted commodities or services cannot by copyrighted or patented. All data, documentation, and innovations become the property of the State of Wisconsin.

27.2 Any material submitted by the vendor in response to this request that the vendor considers confidential and proprietary information and which qualifies as a trade secret, as provided in s. 19.36(5), Wis. Stats., or material which can be kept confidential under the Wisconsin open records law, must be identified on a Designation of Confidential and Proprietary Information form (DOA-3027). Bidders/proposers may request the form if it is not part of the Request for Bid/Request for Proposal package. Bid/proposal prices cannot be held confidential.

28.0 DISCLOSURE: If a state public official (s. 19.42, Wis. Stats.), a member of a state public official's immediate family, or any organization in which a state public official or a member of the official's immediate family owns or controls a ten percent (10%) interest, is a party to this agreement, and if this agreement involves payment of more than three thousand dollars ($3,000) within a twelve (12) month period, this contract is voidable by the state unless appropriate disclosure is made according to s. 19.45(6), Wis. Stats., before signing the contract. Disclosure must be made to the State of Wisconsin Ethics Board, 44 East Mifflin Street, Suite 601, Madison, Wisconsin 53703 (Telephone 608-266-8123).

State classified and former employes and certain University of Wisconsin faculty/staff are subject to separate disclosure requirements, s. 16.417, Wis. Stats.

29.0 RECYCLED MATERIALS: The State of Wisconsin is required to purchase products incorporating recycled materials whenever technically and economically feasible. Bidders are encouraged to bid products with recycled content which meet specifications.

30.0 MATERIAL SAFETY DATA SHEET: If any item(s) on an order(s) resulting from this award(s) is a hazardous chemical, as defined under 29CFR 1910.1200, provide one (1) copy of a Material Safety Data Sheet for each item with the shipped container(s) and one (1) copy with the invoice(s).

31.0 PROMOTIONAL ADVERTISING/ NEWS RELEASES: Reference to or use of the State of Wisconsin, any of its departments, agencies or other subunits, or any state official or employe for commercial promotion is prohibited. News releases pertaining to this procurement shall not be made without prior approval of the State of Wisconsin. Release of broadcast e-mails pertaining to this procurement shall not be made without prior written authorization of the contracting agency.

32.0 HOLD HARMLESS: The Contractor will indemnify and save harmless the State of Wisconsin and all of its officers, agents and employes from all suits, actions, or claims of any character brought for or on account of any injuries or damages received by any persons or property resulting from the operations of the Contractor, or of any of its Contractors, in prosecuting work under this agreement.

33.0 FOREIGN CORPORATION: A foreign corporation (an corporation other than a Wisconsin corporation) which becomes a party to this Agreement is required to conform to all requirements of Chapter 180, Wis. Stats., relating to a foreign corporation and must possess a certificate of authority from the Wisconsin Department of Financial Institutions, unless the corporation is transacting business in interstate commerce or is otherwise exempt from the requirement of obtaining a certificate of authority. Any foreign corporation which desires to apply for a certificate of authority should contact the Department of Financial Institutions, Division of Corporation, P.O. Box 7846, Madison, WI 53707-7846, telephone (608) 266-3590.

APPENDIX: 3A

SUPPLEMENTAL STANDARD TERMS AND CONDITIONS (DOA – 3681)

State of Wisconsin
Department of Administration
DOA-3681 (10/2001)
ss. 16, 19 and 51, Wis. Stats.

Division of Agency Services
Bureau of Procurement

Supplemental Standard Terms and Conditions for Procurements for Services

1.0 ACCEPTANCE OF BID/PROPOSAL CONTENT: The contents of the bid/proposal of the successful Contractor will become contractual obligations if procurement action ensues.

2.0 CERTIFICATION OF INDEPENDENT PRICE DETERMINATION: By signing this bid/proposal, the bidder/proposer certifies, and in the case of a joint bid/proposal, each party thereto certifies as to its own organization, that in connection with this procurement:

2.1 The prices in this bid/proposal have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other bidder/proposer or with any competitor;

2.2 Unless otherwise required by law, the prices which have been quoted in this bid/proposal have not been knowingly disclosed by the bidder/proposer and will not knowingly be disclosed by the bidder/proposer prior to opening in the case of an advertised procurement or prior to award in the case of a negotiated procurement, directly or indirectly to any other bidder/proposer or to any competitor;

2.3 No attempt has been made or will be made by the bidder/proposer to induce any other person or firm to submit or not to submit a bid/proposal for the purpose of restricting competition.

2.4 Each person signing this bid/proposal certifies that: He/she is the person in the bidder's/proposer's organization responsible within that organization for the decision as to the prices being offered herein and that he/she has not participated, and will not participate, in any action contrary to 2.1 through 2.3 above; (or)

He/she is not the person in the bidder's/proposer's organization responsible within that organization for the decision as to the prices being offered herein, but that he/she has been authorized in writing to act as agent for the persons responsible for such decisions in certifying that such persons have not participated, and will not participate in any action contrary to 2.1 through 2.3 above, and as their agent does hereby so certify; and he/she has not participated, and will not participate, in any action contrary to 2.1 through 2.3 above.

3.0 DISCLOSURE OF INDEPENDENCE AND RELATIONSHIP:

3.1 Prior to award of any contract, a potential Contractor shall certify in writing to the procuring agency that no relationship exists between the potential Contractor and the procuring or contracting agency that interferes with fair competition or is a conflict of interest, and no relationship exists between the Contractor and another person or organization that constitutes a conflict of interest with respect to a state contract. The Department of Administration may waive this provision, in writing, if those activities of the potential Contractor will not be adverse to the interests of the state.

3.2 Contractors shall agree as part of the contract for services that during performance of the contract, the Contractor will neither provide contractual services nor enter into any agreement to provide services to a person or organization that is regulated or funded by the contracting agency or has interests that are adverse to the contracting agency. The Department of Administration may waive this provision, in writing, if those activities of the Contractor will not be adverse to the interests of the state.

4.0 DUAL EMPLOYMENT: Section 16.417, Wis. Stats., prohibits an individual who is a State of Wisconsin employe or who is retained as a Contractor full-time by a State of Wisconsin agency from being retained as a Contractor by the same or another State of Wisconsin agency where the individual receives more than $12,000 as compensation for the individual's services during the same year. This prohibition does not apply to individuals who have full-time appointments for less than twelve (12) months during any period of time that is not included in the appointment. It does not include corporations or partnerships.

5.0 EMPLOYMENT: The Contractor will not engage the services of any person or persons now employed by the State of Wisconsin, including any department, commission or board thereof, to provide services relating to this agreement without the written consent of the employing agency of such person or persons and of the contracting agency.

6.0 CONFLICT OF INTEREST: Private and non-profit corporations are bound by ss. 180.0831, 180.1911(1), and 181.225, Wis. Stats., regarding conflicts of interests by directors in the conduct of state contracts.

7.0 RECORDKEEPING AND RECORD RETENTION: The Contractor shall establish and maintain adequate records of all expenditures incurred under the contract. All records must be kept in accordance with generally accepted accounting procedures. All procedures must be in accordance with federal, state and local ordinances.

The contracting agency shall have the right to audit, review, examine, copy, and transcribe any pertinent records or documents relating to any contract resulting from this bid/proposal held by the Contractor. The Contractor will retain all documents applicable to the contract for a period of not less than three (3) years after final payment is made.

INDEPENDENT CAPACITY OF CONTRACTOR: The parties hereto agree that the Contractor, its officers, agents, and employes, in the performance of this agreement shall act in the capacity of an independent Contractor and not as an officer, employe, or agent of the state. The Contractor agrees to take such steps as may be necessary to ensure that each subcontractor of the Contractor will be deemed to be an independent Contractor and will not be considered or permitted to be an agent, servant, joint venturer, or partner of the state.

APPENDIX: 4

VENDOR INFORMATION
(DOA-3477)

WISCONSIN MEDICAID

APPENDIX 4

STATE OF WISCONSIN
DOA-3477 (R05/98)

Bid/Proposal # _____

Commodity/Service _____

VENDOR INFORMATION

1. BIDDING/PROPOSING COMPANY
   NAME _____
   FEIN _____
   Phone ( ) _____ Toll Free Phone ( ) _____
   FAX ( ) _____ E-Mail Address _____
   Address _____
   City _____ State _____ Zip + 4 _____

2. Name the person to contact for questions concerning this bid/proposal.
   Name _____ Title _____
   Phone ( ) _____ Toll Free Phone ( ) _____
   FAX ( ) _____ E-Mail Address _____
   Address _____
   City _____ State _____ Zip + 4 _____

3. Any vendor awarded over $25,000 on this contract must submit affirmative action information to the Department. Please name the Personnel/Human Resource and Development or other person responsible for affirmative action in the company to contact about this plan.
   Name _____ Title _____
   Phone ( ) _____ Toll Free Phone ( ) _____
   FAX ( ) _____ E-Mail Address _____
   Address _____
   City _____ State _____ Zip + 4 _____

4. Mailing address to which state purchase orders are mailed and person the Department may contact concerning orders and billings.
   Name _____ Title _____
   Phone ( ) _____ Toll Free Phone ( ) _____
   FAX ( ) _____ E-Mail Address _____
   Address _____
   City _____ State _____ Zip + 4 _____

5. CEO/President Name _____

This document can be made available in accessible formats to qualified individuals with disabilities.

APPENDIX: 4A

VENDOR REFERENCE
(DOA-3478)

WISCONSIN MEDICAID

APPENDIX 4A

STATE OF WISCONSIN
DOA-3478 (R12/96)

Bid/Proposal # _____

VENDOR REFERENCE

FOR VENDOR: _____

Provide company name, address, contact person, telephone number, and appropriate information on the product(s) and/or service(s) used for four (4) or more installations with requirements similar to those included in this solicitation document. If vendor is proposing any arrangement involving a third party, the named references should also be involved in a similar arrangement.

Company Name _____

Address (include Zip + 4) _____

Contact Person _____ Phone No. _____

Product(s) and/or Service(s) Used _____

_____

_____

Company Name _____

Address (include Zip + 4) _____

Contact Person _____ Phone No. _____

Product(s) and/or Service(s) Used _____

_____

_____

Company Name _____

Address (include Zip + 4) _____

Contact Person _____ Phone No _____

Product(s) and/or Service(s) Used _____

_____

_____

Company Name _____

Address (include Zip + 4) _____

Contact Person _____ Phone No. _____

Product(s) and/or Service(s) Used _____

_____

_____

This document can be made available in accessible formats to qualified individuals with disabilities.

APPENDIX: 5

PROHIBITION AGAINST DISCLOSURE OF INFORMATION (42 USC Sec. 1320c-9)

42 USC sec. 1320c-9. PROHIBITION AGAINST DISCLOSURE OF INFORMATION

(a) Freedom of Information Act inapplicable; exceptions to nondisclosure
An organization, in carrying out its functions under a contract entered into under this part, shall not be a Federal agency for purposes of the provisions of section 552 of title 5 (commonly referred to as the Freedom of Information Act). Any data or information acquired by any such organization in the exercise of its duties and functions shall be held in confidence and shall not be disclosed to any person except -

(1) to the extent that may be necessary to carry out the purposes of this part,

(2) in such cases and under such circumstances as the Secretary shall by regulations provide to assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care, or

(3) in accordance with subsection (b) of this section.

(b) Disclosure of information permitted An organization having a contract with the Secretary under this part shall provide in accordance with procedures and safeguards established by the Secretary, data and information -

(1) which may identify specific providers or practitioners as may be necessary -

(A) to assist Federal and State agencies recognized by the Secretary as having responsibility for identifying and investigating cases or patterns of fraud or abuse, which data and information shall be provided by the peer review organization to any such agency at the request of such agency relating to a specific case or pattern;

(B) to assist appropriate Federal and State agencies recognized by the Secretary as having responsibility for identifying cases or patterns involving risks to the public health, which data and information shall be provided by the peer review organization to any such agency -

(i) at the discretion of the peer review organization, at the request of such agency relating to a specific case or pattern with respect to which such agency has made a finding, or has a reasonable belief, that there may be a substantial risk to the public health, or

(ii) upon a finding by, or the reasonable belief of, the peer review organization that there may be a substantial risk to the public health;

(C) to assist appropriate State agencies recognized by the Secretary as having responsibility for licensing or certification of providers or practitioners or to assist national accreditation bodies acting pursuant to section 1395bb of this title in accrediting providers for purposes of meeting the conditions described in subchapter XVIII of this chapter, which

data and information shall be provided by the peer review organization to any such agency or body at the request of such agency or body relating to a specific case or to a possible pattern of substandard care, but only to the extent that such data and information are required by the agency or body to carry out its respective function which is within the jurisdiction of the agency or body under State law or under section 1395bb of this title; and

(D) to provide notice in accordance with section 1320c-3(a)(9)(B) of this title;

(2) to assist the Secretary, and such Federal and State agencies recognized by the Secretary as having health planning or related responsibilities under Federal or State law (including health systems agencies and State health planning and development agencies), in carrying out appropriate health care planning and related activities, which data and information shall be provided in such format and manner as may be prescribed by the Secretary or agreed upon by the responsible Federal and State agencies and such organization, and shall be in the form of aggregate statistical data (without explicitly identifying any individual) on a geographic, institutional, or other basis reflecting the volume and frequency of services furnished, as well as the demographic characteristics of the population subject to review by such organization. The penalty provided in subsection (c) of this section shall not apply to the disclosure of any information received under this subsection, except that such penalty shall apply to the disclosure (by the agency receiving such information) of any such information described in paragraph (1) unless such disclosure is made in a judicial, administrative, or other formal legal proceeding resulting from an investigation conducted by the agency receiving the information. An organization may require payment of a reasonable fee for providing information under this subsection in response to a request for such information.

(c) Penalties

It shall be unlawful for any person to disclose any such information described in subsection (a) of this section other than for the purposes provided in subsections (a) and (b) of this section, and any person violating the provisions of this section shall, upon conviction, be fined not more than $1,000, and imprisoned for not more than 6 months, or both, and shall be required to pay the costs of prosecution.

(d) Subpoena and discovery proceedings regarding patient records

No patient record in the possession of an organization having a contract with the Secretary under this part shall be subject to subpoena or discovery proceedings in a civil action. No document or other information produced by such an organization in connection with its deliberations in making determinations under section 1320c-3(a)(1)(B) or 1320c-5(a)(2) of this title shall be subject to subpoena or discovery in any administrative or civil proceeding; except that such an organization shall provide, upon request of a practitioner or other person adversely affected by such a determination, a summary of the organization's findings and conclusions in making the determination.

(e) Organizations with contracts

For purposes of this section and section 1320c-6 of this title, the term ''organization with a contract with the Secretary under this part'' includes an entity with a contract with the Secretary under section 1320c-3(a)(4)(C) of this title.

APPENDIX: 6

COST PROPOSAL, INSTRUCTIONS AND FORMS

WISCONSIN MEDICAID

APPENDIX: 6

COST PROPOSAL, INSTRUCTIONS AND FORMS

Bidders are required to follow the instructions and use the forms contained in this appendix for preparation of the Cost Proposal in response to this RFB. Bidders must complete the following forms:

- Medicaid Health Care Reviews Proposed Costs (Appendix 6A)
- Review Time and Cost Report (Appendix 6B)

Bidders are also required to complete and submit a detailed budget narrative for each of the line items contained in the Medicaid Health Care Reviews Proposed Cost form.

The State will verify the accuracy of the statement of costs, all bids will be rated with the lowest cost proposal as number one; the next lowest as number two; etc. Only if the cost bid is so low that the Department finds it cannot be responsible, the bid will be assigned a lower ranking or be rejected altogether.

A. MEDICAID HEALTH CARE REVIEWS PROPOSED COSTS FORM

The Medicaid Health Care Reviews Cost Proposal must contain a completed Medicaid Health Care Reviews Proposed Costs form (Appendix 6A) and a budget narrative. The form in Appendix 6A and the budget narrative must be prepared for the first contract year period. Costs of performing the reviews are to be proposed as follows.

DIRECT REVIEWER COSTS

I. RN Reviewers

To complete the RN Reviewer schedule, list each position title, the percent of time devoted to contract responsibilities with 100 percent of time equal to 2080 hours per year (i.e., one full time equivalent), base salary and cost of fringe benefits. The personnel costs must include any anticipated increases in salary or fringe over the duration of the contract. It is expected that the selected bidder will have sufficient resources to handle the required reviews presented in the RFB; therefore, overtime pay is not an allowable cost. Incentive pay is not an allowable Personnel cost.

II. Physician Reviewers

To complete the Physician Reviewer schedule, list each reviewer, their expertise, and the proposed cost of their services in the same format as for the RN Reviewers.

III. Physician/Expert Consultants

To complete the Physician/Expert consultant schedule, list each consultant, their expertise, and the proposed cost of their services in the same format as for the RN Reviewers.

ADMINISTRATIVE AND GENERAL AND FIXED COSTS

IV. Personnel

List all other personnel not listed in I and II above and complete according to instructions given in I.

V. Office Operations

Separately prepare proposed costs line item costs for Supplies, Copying, Printing, Postage, Heat, Lights, Telephone and other. Do not include as costs under copying the expenses incurred by hospitals for the copying of their medical records. These costs will be handled under subsection 60.200. The Department will reimburse the Contractor the actual amount to be paid by the Contractor to hospitals and HMOs for copying medical records and postage or equivalent shipping costs for medical records sent to the Contractor.

VI. Rent

List the costs for rental of office space and the rental cost of any office equipment and furniture needed to meet the requirements specified in this Request for Proposals.

VII. Data Processing

List the costs of data processing proposed to perform the activities outlined in PART 3: TECHNICAL SPECIFICATIONS.

VIII. RN and Physician Reviewer Travel

The proposed costs for local and non-local travel shall be separately listed for RN and Physician Reviewers by local and non-local trips. Travel estimates shall be based upon the proposer's current policies.

IX. Subcontracts (identify)

Identify and describe subcontracts for all services, supplies or equipment that are not included in other sections.

X. Depreciation (identify)

List depreciation on all assets owned by the Proposer which will be used to meet the requirements of this RFB. Depreciation shall be taken on a straight line basis over the useful life of the assets.

XI. Other Costs

List all other costs not identified above that are related to the performance of the reviews. These costs are typically those incurred as a result of doing business.

BUDGET NARRATIVE

Listed below is a description of the information that is required in the Budget Narrative. Each cost category is organized by Roman numeral corresponding to the item on the Medicaid Health Care Reviews Proposed Cost Form.

I. **RN Reviewers**: In addition to the information required on the Health Care Reviews Proposed Cost form, include a detailed description of the activities of each Reviewer position as it relates to the Medicaid Reviews.

Fringe Benefits: Indicate what benefits will be provided and how the amount was calculated. If different rates were used for different individuals, the narrative must contain a table summarizing the calculation of each individual. For example:

Sample Table	**Salary**	**Fringe Rate**	**Fringes**	**Percent of Time**
Review Manager	35,000	.20	7,000	50%
Nurse Reviewer	30,000	.20	6,000	75%

II. **Physician Reviewers**: The need for each Physician Reviewer must be outlined in detail. A work plan for each, including the tasks to be accomplished, shall be included. List fees for each advisor by hourly rate and give total for each advisor. For example:

Total physician advisor costs are $_____/year. Dr. Smith will provide health care review expertise in the area of surgical services and serve as liaison with the hospitals. He will participate in meetings of review staff, and work with the nurse reviewers in the review of any requested reconsideration. Dr. Smith will be paid $_____/hr for _____ hours in year 1 for a total of $_____.

If the Physician Reviewer is an employee use instructions as described for RN Reviewers.

III. **Physician/Expert Consultant**: The need for each Physician/Expert Consultant must be outlined in detail. List fees for each advisor/consultant by hourly rate and give a total for each. For example:

Total physician/expert consultant costs are $_____/year. Dr. Smith will provide health care review expertise in the area of surgical services and serve as liaison with the hospitals. He will participate in meetings of review staff, and work with the nurse reviewers in the review of any requested reconsideration. Dr. Smith will be paid $_____/hr for _____ hours in year 1 for a total of $_____.

If the physician/expert consultant is an employee use instructions as described for RN Reviewers.

IV. **Personnel**: Include a detailed description of the activities of each non-reviewer position as the position relates to the Medicaid Reviews and what benefits will be provided. Use instructions under I. RN Reviewer.

V. **Office Operations**: The estimated costs for Supplies, Copying, Printing, Postage, Heat, Lights, Telephone, and other shall be provided separately along with a description of how estimates for each were determined. For example to maintain 2 office sites:

- *Supplies* - if the cost of supplies for one year of review activity at the two sites is $1,000. This includes $400 for stationary plus $50 per month for miscellaneous supplies such as paper clips, tape, copier toner, files, and paper ($50 x 12 months = $600).

- *Copying* - if copying of correspondence, computer printouts, and other documents at the two sites are estimated for each site to be 2,000 copies x $0.05/copy x 12 months = $1,200 x 2 sites = $2,400 in copying cost for one year.

NOTE: Copying of hospital medical records are not to be included as a cost under this contract. These costs will be reimbursed under separate payment pursuant to subsection 60.200.

- *Postage* - costs for mailing correspondence, reports, etc. is estimated at $25/mo. x 12 months = $300.

- *Telephone* - The estimate for telephone includes three (3) incoming lines and four (4) extensions for example:

Purchase of main phone- 3 incoming lines	=	$120
Rent of 4 extensions @ $5.00/phone/month	=	$240
Long Distance Calls between 2 sites ($25/mo. x 2 sites x 12 months)	=	$600
Long Distance Calls to Hospitals ($50/mo. x 12 months)	=	$600
Total telephone costs	=	$1,560

VI. **Rental:** The rental costs of office space, equipment and furniture is to be described in detail. Example:

- We propose to use 150 square feet of our existing space in each of our 2 existing facilities to perform the required reviews. Our lease agreement at both sites for 1994 -1996 includes maintenance. The monthly rental rate of $10/sq. ft. per month. There are no other costs to provide space to perform reviews. Therefore, the cost for space is 2 sites x 150 Sq. Ft. x $10 x 12 months = $36,000.

- We propose to rent 4 secure file storage cabinets for the safe keeping of medical records at a cost of $50.00 per cabinet per year. Therefore, the cost of secure storage will be 4 cabinets X $50 = $200.

VII. **Data Processing**: Computer tapes containing one months claims will be provided by the Medicaid Fiscal Agent and the data will be transferred to the Contractor's computer to identify cases for review. For example:

We estimate of one (1) CPU hour per month at $60 per hour. Total cost = $720.

VIII. **RN and Physician Reviewer Travel**: The estimated costs for local and non-local travel shall be described in this section. The basis of the calculation as well as the purpose for all travel shall be provided. Identify specific destinations and rates for transportation, meals and lodging for non-local travel. For example:

- *Local Travel* - Local travel for a monthly meeting with State staff. Four staff persons will attend the monthly meetings. Travel costs are estimated at 10 miles a trip x 12 meetings x $0.25/mile = $30.

Any Physician Reviewer travel shall also be shown as above. As with the RN Reviewer travel, the travel costs shall be described in detail including the basis of the calculation and the destination and purpose of the proposed trips.

IX. **Subcontracts**: For each proposed subcontract you must provided a separate line item cost schedule and a separate narrative as described above. The same level of detail and restrictions apply. An introductory paragraph in the narrative shall

explain the services to be provided under the subcontract. A draft of the proposed subcontract (which includes but not be limited to the scope of work, the parties involved, the proposed costs, and the subcontract period) is to be included as an attachment to the narrative.

X. **Depreciation**: List each asset or asset group separately, its historical cost, useful life, and percent devoted to completing the requirements of this RFB.

XI. **Other Costs**: Provide a list and a narrative of all other costs, which are included in this line. The narrative shall be specific in detailing what types of items are included and the basis for cost determination.

B. REVIEW TIME AND COST REPORT FORM

The Review Time and Cost Report form in Appendix 6B is to be completed to submit the price for the performance of the reviews specified in this RFB. The proposed price for the reviews is the sum of the costs bid for each of the types of reviews listed as total for column 13. The proposed price for the reviews is considered binding for six (6) months after the submittal date of the proposal.

C. SPECIAL MANAGED CARE ORGANIZATION REVIEW CONSIDERATION

At this point in the preparation of the RFB, it is unclear if how many Special Managed Care Organizations will be included in this RFB. Their inclusion or exclusion will be made known to all bidders as soon as this determination is made by the DHCF. Accordingly, bidders will be asked to include or not include the cost of the review work related to those SMCOs.

APPENDIX: 6A

HEALTH CARE REVIEWS
PROPOSED COSTS

WISCONSIN MEDICAID

APPENDIX: 6A
HEALTH CARE REVIEWS PROPOSED COSTS
from July 1, 2004, to June 30, 2005

DIRECT REVIEWER COSTS:

I	RN Reviewers	Name of Reviewer	Position	Base Salary or Contract	Fringe Rate	Fringe Benefits	Percent of Time	Total Cost
	Sub Total							
II	Physician Reviewers	Name of Reviewer	Position	Base Salary or Contract	Fringe Rate	Fringe Benefits	Percent of Time	Total Cost
	Sub Total							
III	Administrative Personnel	Name of Reviewer	Position	Base Salary or Contract	Fringe Rate	Fringe Benefits	Percent of Time	Total Cost
	Sub Total							
IIV	Physician/Expert Consultants	Name of Consultant	Area of Expertise	Base Salary or Contract	Fringe Rate	Fringe Benefits	Percent of Time	Total Cost
	Sub Total							
	Grand Total							

APPENDIX: 6B

REVIEW TIME AND COST REPORT

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APPENDIX: 6B

REVIEW TIME AND COST REPORT REFERENCE TABLE

Description	Section
ADMISSION REVIEWS 80.100	
A. Delayed Admission Review	80.120 & 80.540
RETROSPECTIVE REVIEWS 80.200	
B. Targeted Admission Review	80.210
C. Short Stays Review	80.220
D. Readmissions Review	80.230
OTHER REVIEWS 80.300 – 80.400	
E. Reconsideration of Retrospective Denial Reviews	80.300
F. DHCF Referrals Review	80.400
MENTAL HEALTH/SUBSTANCE ABUSE SERVICE REVIEWS 80.500	
G. Inpatient Mental Health/Substance Abuse Review	80.510
H. Telephonic Admission Review	80.520
I. Suspect Admissions Review	80.530
J. Retrospective MH/SA Chart Review	80.550
K. Retrospective MH/SA Chart Review of Special Cases	80.560
L. Retrospective Eligibility Review of Special Cases	80.580
M. Quality of Care Review	80.600
N. DRG Data Validation Review	80.700
CON NON-EMERGENCY ADMISSIONS 90.100	
O. MH/SA Retrospective CON Review	90.110
P. Emergency Admissions CON Review	90.120
Q. Application to Medicaid While Hospitalized CON Review	90.130
HMO REVIEWS – 100	
R. Focused Provider Reviews	100.101
S. Performance Improvement Project Review	100.102
T. Medical Record Quality of Care Review	100.103
U. Data Validity Audits	100.400
FEE FOR SERVICE RETROSPECTIVE REVIEWS 110	
V. Retrospective Review	110.110
W. Focused Provider Review	110.120
X. Chronic Conditions Review	110.130
Y. Targeted Physician Review	110.140
Z. Random Sample of Ambulatory Surgical Cases	110.150
SPECIAL MANAGED CARE REVIEWS 120	
AA. On-site Review	120.100
BB. Performance Improvement Project Evaluation Review	120.200

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REVIEW TIME AND COST REPORT
HEALTH CARE REVIEWS FOR CONTRACT PERIOD 07/01/2004 - 06/30/2005

	1 Review Category	2 Est. No of Cases	3 Est. % Refer to MD	4 Avg. RN Min/ Case For ALL Cases	5 Est. RN Direct Review Hours	6 Est. RN Direct Review Costs	7 Avg. MD Min. per Case Referred	8 Est. MD Direct Review Hours	9 Est. MD Direct Review	10 Est. Total Direct Review Costs	11 Review Cost Per Case or Study	12 Allocated Share of Other Direct & Indirect	13 Total Costs	14 Total Cost Per Case or Study
A.	Delayed Admission													
B.	Targeted Admission													
C.	Short Stays													
D.	Readmissions													
E.	Reconsideration of Retro Denials													
F.	DHCF Referrals													
G.	Inpatient MH/SA Review													
H.	Telephonic Admission													
I.	Suspect Admission													
J.	Retrospective Eligibility													
K.	Retrospective MH/SA Special													
L.	Retrospective Eligibility Special													
M.	Quality of Care													
N.	DRG Data Validation													
O.	MH/SA Retrospective CON													
P.	Emergency Admissions CON													
Q.	Application to MA in Hospital													
R.	Focused Provider													
S.	MCO PIPs													
T.	MCO Med Record Quality of Care													

	1 Review Category	2 Est. No of Cases	3 Est. % Refer to MD	4 Avg. RN Min/ Case For ALL Cases	5 Est. RN Direct Review Hours	6 Est. RN Direct Review Costs	7 Avg. MD Min. per Case Referred	8 Est. MD Direct Review Hours	9 Est. MD Direct Review	10 Est. Total Direct Review Costs	11 Review Cost Per Case or Study	12 Allocated Share of Other Direct & Indirect	13 Total Costs	14 Total Cost Per Case or Study
U.	Data Validity Audits													
V.	Retrospective													
W.	Focused Provider													
X.	Chronic Conditions													
Y.	Targeted Physician													
Z.	Random Sample of Amb Surg Cases													
AA.	SMCO On-Site Review													
BB.	SMCO P I Ps													
	GRAND TOTAL													

APPENDIX: 7

MEDICAID PRE-ADMISSION/PRE-PROCEDURE REVIEW CONTROL NUMBER

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APPENDIX 7

MEDICAID PRE-ADMISSION/DELAYED ADMISSION REVIEW CONTROL NUMBER

Control number employs Modulus-10 check digit system

Positions	Field Name	Values
1-6	System-assigned number	000001-799999 (Elective Med/Surg) 800000-999999 (Mental Health/Substance Abuse
7	Filler	0
8	Admission Review Results	1 = Approved by RN 2 = Suspect by RN
9	Filler	6
10	Check Digit	0-9

APPENDIX: 8

EXAMPLES
MEDICAID DRG GROUPER LOGIC

WISCONSIN MEDICAID

APPENDIX: 8

MEDICAID DRG GROUPER LOGIC EXAMPLES

NEONATAL DRG GROUPER

Following is the narrative description of the logic used to reassign Medicare DRGs 385 through 391 to Wisconsin Medicaid neonatal DRGs 601 through 680.

Step 1. A neonatal claim will be reassigned to one of the new neonatal Wisconsin Medicaid DRGs if the claim would have originally grouped into Medicare DRGs 385 through 391. The selection criteria for all the following steps is to determine whether the claim can first be assigned to one of the Medicare DRGs, 385 through 391.

Step 2. Test whether the claim is for services provided to a neonate who died within one (1) day of admission by subtracting the admission date from the discharge date.

If the result is less than or equal to one and the patient was born in the admitting (your) hospital but died within one (1) day, the DRG is reassigned to 601.

But if the claim is for a neonate transferred from another hospital to your hospital and the neonate died within one (1) day (the discharge date minus the admission date is less than or equal to one), the DRG is reassigned to 602.

Step 3. If the claim does not meet the criteria in step 2, then determine whether the recipient was transferred to another hospital within four (4) days.

Subtract the admission date from the discharge date. If the result is less than or equal to four, and the claim indicates the patient was transferred to another hospital, then the DRG is reassigned to 604.

Note regarding steps 4 through 8: If the claim is for a neonate who neither died within one (1) day of admission nor was transferred to another hospital within four (4) days of birth, then birth weight becomes the major determining factor in reassigning the DRG. The neonate's birth weight is identified by ICD-9-CM diagnosis codes 764.01 through 765.18. The patient's birth weight must be identified on the UB-82 claim form as an ICD-9-CM diagnosis code in any of the diagnosis code fields, items 77 through 81.

If none of the diagnosis codes indicated on the claim form are for birth weight, a normal birth weight of 2500 grams is assumed.

Step 4. If the neonate's birth weight was less than 750 grams and the neonate died in the hospital, DRG 610 will be reassigned to the claim. If the neonate was discharged alive, DRG 614 will be reassigned.

Step 5. If the neonate's birth weight was between 750 and 999 grams and the neonate died in the hospital, DRG 620 will be reassigned to the claim. If the neonate was discharged alive, DRG 624 will be reassigned.

Step 6. If the neonate birth weight was between 1,000 and 1,499 grams and the neonate died in the hospital, DRG 637 will be reassigned to the claim.

If the neonate (whose birth weight is between 1,000 and 1,499 grams) was discharged alive, the next test is whether an operating room (O.R.) procedure (excluding circumcision) was performed. If an O.R. procedure was performed, DRG 638 shall be reassigned to the claim. If an O.R. procedure was not performed, DRG 639 will be reassigned.

Step 7. If the claim indicates the neonate's birth weight was between 1,500 and 1,999 grams and the neonate underwent an operating room procedure, then the claim is reassigned to DRG 648. If an operating room procedure was not performed, DRG 649 will be reassigned.

Note on the logic in step 8: The following logic is presented for two birth weight groups:

(a) Patients whose birth weights were between 2,000 and 2,499 grams, and

(b) Patients whose birth weights were 2,500 grams or more. Birth weights of 2,500 grams or more, and their DRG reassignments, will be indicated in parentheses.

Step 8. If the claim indicates a neonate's birth weight was between 2,000 and 2,499 grams (or 2,500 grams or more) and the neonate underwent an operating room procedure (excluding circumcision), then the claim is reassigned to DRG 650 (or DRG 680 if the birth weight is 2,500 grams or more).

If no operating room procedure was performed, then the claim must be tested for the presence of a major or minor medical condition.

Note: A major medical condition is defined as a condition or set of conditions that when present, would cause the claim to group into one of the Medicare DRGs 386, 387, or 389 in MDC 15. A minor medical condition is identified as a condition or set of conditions that, if present, would cause the claim to group into one of the Medicare DRGs 388 or 390 in MDC 15.

If the claim indicates no operating room procedure, a patient's birth weight between 2,000 and 2,499 grams (or 2,500 grams or more) and a major medical condition, then the claim is reassigned to DRG 656 (DRG 676 if birth weight is 2,500 grams or more).

If the conditions for a major medical condition are not present, then the claim must be tested for presence of a minor medical condition. If a minor problem is indicated, the birth weight is between 2,000 and 2,499 grams (or 2,500 grams or more), and no

operating room procedure is indicated, then the claim is reassigned to DRG 657 (DRG 677 if birth weight is 2,500 grams or more).

If the claim indicates the patient's birth weight was between 2,000 and 2,499 grams (or 2,500 grams or more), an operating room procedure is not indicated, and neither a major nor a minor medical condition is present, then the claim is reassigned to DRG 670 (DRG 678 if birth weight is 2,500 grams or more.

All normal newborn claims for patients born under normal birth conditions and with normal birth weight (2,500 grams or more) will be assigned, under the above logic, to DRG 678.

PSEUDO-CODE
= = = = = = = = = = = = =

If DRG from grouper >= 385 and <= 391 then

    Perform Neo-Natal Patch logic

endif

Neo-Natal Patch Logic
= = = = = = = = = = = = = = = = = =

Calculate Length of Stay = Discharge Date - Admission Date

If Length of Stay <= 1 and Patient Status Code = 20 then

    If Source of Admission <> (not equal to) 4

        DRG = 601 Died in birth hospital

    else

        DRG = 602 Died in receiving hospital

    endif

else

    If Length of Stay > 0 and Length of Stay <= 4

        If Patient Status Code = {02 03 04 05 06 07}

            DRG = 604

        else

            Perform Birth-weight procedure

        endif

    else

        Perform Birth-weight DRG procedure

    endif

endif

Birth-weight DRG procedure
= =

Perform Calculate Birth-weight Procedure using birth-weight

If birth-weight < 750 grams

    If discharge status = 20 then

        DRG = 610

    else

        DRG = 614

    endif

endif

If birth-weight >= 750 grams and birth-weight < 1000 grams

    If discharge status = 20

        DRG = 620

    else

        DRG = 624

    endif

endif

If birth-weight >= 1000 and birth-weight < 1500 grams

    If discharge status = 20

        DRG = 637

    else

        IF O.R. Procedure exists (from grouper table) and O.R. Procedure <> 640

            DRG = 638

        else

DRG = 639

endif

endif

endif

If birth-weight >= 1500 grams and birth-weight < 2000 grams

If O.R. Procedure exists and procedure code <> 640 (circumcision)

DRG = 648

else

DRG = 649

endif

endif

If birth-weight >= 2000 grams and birth-weight < 2500 grams

If O.R. Procedure exists and procedure code <> 640 (circumcision)

DRG = 650

else

If Major Problem (DRGs 386, 387 and 389)

DRG = 656

else

If Minor Problem (DRGs 388, 390)

DRG = 657

else

DRG = 670

endif

endif

endif

endif

If birth-weight > = 2500 grams

If O.R. Procedure exists and procedure code <> 640

DRG = 680

else

If Major Problem (DRG 386, 387, 389)

DRG = 676

else

If Minor Problem (DRG 388, 390)

DRG = 677

else

DRG = 678

endif

endif

endif

else

DRG = 697

endif

Calculate Birth-weight Procedure
= =
IF diagnoses = * any of the discharge diagnoses 1-5

764.01	764.02	764.11	764.12	764.21
764.22	764.91	764.92	765.01	765.02
765.11	765.12			

```
        birth-weight = 749 grams

else

        if diagnoses = {764.03     764.13     764.23     764.93     765.03     765.13}

                birth-weight = 999 grams

        else

                if diagnoses = {764.04     764.05     764.14     764.15     764.24 764.25
                                764.94     764.95     765.04     765.05    765.14     765.15}

                        birth-weight = 1499 grams

                else

                        if diagnoses = {764.06     764.07     764.16     764.17     764.26     764.27
                                        764.96     764.97     765.06     765.07     765.16     765.17}

                                birth-weight = 1999 grams

                        else

                                if diagnoses = {764.08     764.18     764.28     764.98     765.08     765.18}

                                        birth-weight = 2499 grams

                                else

                                        birth-weight = 2500 grams

                                endif

                        endif

                endif

        endif
                                                endif
```

DRG Description	DRG
1. If Hospital = Milwaukee Co. Mental Health Center	
If Medicare DRG = 424 and Age < 18 then Medicaid Psych DRG	= 701
If Medicare DRG = 424 and Age ≥ 18 then Medicaid Psych DRG	= 702
If Medicare DRG = 425 and Age < 18 then Medicaid Psych DRG	= 703
If Medicare DRG = 425 and Age ≥ 18 then Medicaid Psych DRG	= 704
If Medicare DRG = 426 and Age < 18 then Medicaid Psych DRG	= 705
If Medicare DRG = 426 and Age ≥ 18 then Medicaid Psych DRG	= 706
If Medicare DRG = 427 and Age < 18 then Medicaid Psych DRG	= 707
If Medicare DRG = 427 and Age ≥ 18 then Medicaid Psych DRG	= 708
If Medicare DRG = 428 and Age < 18 then Medicaid Psych DRG	= 709
If Medicare DRG = 428 and Age ≥ 18 then Medicaid Psych DRG	= 710
If Medicare DRG = 429 and Age < 18 then Medicaid Psych DRG	= 711
If Medicare DRG = 429 and Age ≥ 18 then Medicaid Psych DRG	= 712
If Medicare DRG = 430 and Age < 18 then Medicaid Psych DRG	= 713
If Medicare DRG = 430 and Age ≥ 18 then Medicaid Psych DRG	= 714
If Medicare DRG = 431 and Age < 18 then Medicaid Psych DRG	= 715
If Medicare DRG = 431 and Age ≥ 18 then Medicaid Psych DRG	= 716
If Medicare DRG = 432 and Age < 18 then Medicaid Psych DRG	= 717
If Medicare DRG = 432 and Age ≥ 18 then Medicaid Psych DRG	= 718
2. If Hospital = IMDs	
If Medicare DRG = 424 and Age < 18 then Medicaid Psych DRG	= 721
If Medicare DRG = 424 and Age ≥ 18 then Medicaid Psych DRG	= 722
If Medicare DRG = 425 and Age < 18 then Medicaid Psych DRG	= 723
If Medicare DRG = 425 and Age ≥ 18 then Medicaid Psych DRG	= 724
If Medicare DRG = 426 and Age < 18 then Medicaid Psych DRG	= 725
If Medicare DRG = 426 and Age ≥ 18 then Medicaid Psych DRG	= 726
If Medicare DRG = 427 and Age < 18 then Medicaid Psych DRG	= 727
If Medicare DRG = 427 and Age ≥ 18 then Medicaid Psych DRG	= 728
If Medicare DRG = 428 and Age < 18 then Medicaid Psych DRG	= 729
If Medicare DRG = 428 and Age ≥ 18 then Medicaid Psych DRG	= 730
If Medicare DRG = 429 and Age < 18 then Medicaid Psych DRG	= 731
If Medicare DRG = 429 and Age ≥ 18 then Medicaid Psych DRG	= 732
If Medicare DRG = 430 and Age < 18 then Medicaid Psych DRG	= 733
If Medicare DRG = 430 and Age ≥ 18 then Medicaid Psych DRG	= 734
If Medicare DRG = 431 and Age < 18 then Medicaid Psych DRG	= 735
If Medicare DRG = 431 and Age ≥ 18 then Medicaid Psych DRG	= 736
If Medicare DRG = 432 and Age < 18 then Medicaid Psych DRG	= 737
If Medicare DRG = 432 and Age ≥ 18 then Medicaid Psych DRG	= 738
3. If Hospital = Medicare Psych Exempt Unit	
If Medicare DRG = 424 and Age < 18 then Medicaid Psych DRG	= 741
If Medicare DRG = 424 and Age ≥ 18 then Medicaid Psych DRG	= 742
If Medicare DRG = 425 and Age < 18 then Medicaid Psych DRG	= 743

DRG Description	DRG
If Medicare DRG = 425 and Age ≥ 18 then Medicaid Psych DRG	= 744
If Medicare DRG = 426 and Age < 18 then Medicaid Psych DRG	= 745
If Medicare DRG = 426 and Age ≥ 18 then Medicaid Psych DRG	= 746
If Medicare DRG = 427 and Age < 18 then Medicaid Psych DRG	= 747
If Medicare DRG = 427 and Age ≥ 18 then Medicaid Psych DRG	= 748
If Medicare DRG = 428 and Age < 18 then Medicaid Psych DRG	= 749
If Medicare DRG = 428 and Age ≥ 18 then Medicaid Psych DRG	= 750
If Medicare DRG = 429 and Age < 18 then Medicaid Psych DRG	= 751
If Medicare DRG = 429 and Age ≥ 18 then Medicaid Psych DRG	= 752
If Medicare DRG = 430 and Age < 18 then Medicaid Psych DRG	= 753
If Medicare DRG = 430 and Age ≥ 18 then Medicaid Psych DRG	= 754
If Medicare DRG = 431 and Age < 18 then Medicaid Psych DRG	= 755
If Medicare DRG = 431 and Age ≥ 18 then Medicaid Psych DRG	= 756
If Medicare DRG = 432 and Age < 18 then Medicaid Psych DRG	= 757
If Medicare DRG = 432 and Age ≥ 18 then Medicaid Psych DRG	= 758
4. If Hospital = All Other Hospitals	
If Medicare DRG = 424 and Age < 18 then Medicaid Psych DRG	= 761
If Medicare DRG = 424 and Age ≥ 18 then Medicaid Psych DRG	= 762
If Medicare DRG = 425 and Age < 18 then Medicaid Psych DRG	= 763
If Medicare DRG = 425 and Age ≥ 18 then Medicaid Psych DRG	= 764
If Medicare DRG = 426 and Age < 18 then Medicaid Psych DRG	= 765
If Medicare DRG = 426 and Age ≥ 18 then Medicaid Psych DRG	= 766
If Medicare DRG = 427 and Age < 18 then Medicaid Psych DRG	= 767
If Medicare DRG = 427 and Age ≥ 18 then Medicaid Psych DRG	= 768
If Medicare DRG = 428 and Age < 18 then Medicaid Psych DRG	= 769
If Medicare DRG = 428 and Age ≥ 18 then Medicaid Psych DRG	= 770
If Medicare DRG = 429 and Age < 18 then Medicaid Psych DRG	= 771
If Medicare DRG = 429 and Age ≥ 18 then Medicaid Psych DRG	= 772
If Medicare DRG = 430 and Age < 18 then Medicaid Psych DRG	= 773
If Medicare DRG = 430 and Age ≥ 18 then Medicaid Psych DRG	= 774
If Medicare DRG = 431 and Age < 18 then Medicaid Psych DRG	= 775
If Medicare DRG = 431 and Age ≥ 18 then Medicaid Psych DRG	= 776
If Medicare DRG = 432 and Age < 18 then Medicaid Psych DRG	= 777
If Medicare DRG = 432 and Age ≥ 18 then Medicaid Psych DRG	= 778

APPENDIX: 9

BORDER STATUS HOSPITALS

WISCONSIN MEDICAID

APPENDIX: 9
BORDER STATUS HOSPITALS

Hospital Name	City	State
UNITED HOSPITALS INCORPORATE	ST PAUL	MN
LAKE CITY HOSPITAL	LAKE CITY	MN
MERCY HOSPITAL	COON RAPIDS	MN
HARVARD COMMUNITY MEMORIAL	HARVARD	IL
MEMORIAL HOSPITAL	WOODSTOCK	IL
SWEDISH AMERICAN HOSPITAL	ROCKFORD	IL
SAINT ANTHONY MEDICAL CENTER	ROCKFORD	IL
ROCKFORD MEMORIAL HOSPITAL	ROCKFORD	IL
MERCY MEDICAL CENTER	DUBUQUE	IA
FINLEY HOSPITAL	DUBUQUE	IA
DICKINSON CO MEMORIAL HOSPITAL	IRON MOUNTAIN	MI
GRAND VIEW HOSPITAL	IRONWOOD	MI
IRON COUNTY GENERAL HOSPITAL	IRON RIVER	MI
CRYSTAL FALLS COMM HOSPITAL	CRYSTAL FALLS	MI
GILLETTE CHILDREN'S HOSPITAL	ST PAUL	MN
NORTH MEMORIAL MEDICAL	ROBBINSDALE	MN
ST MARYS MEDICAL CENTER	DULUTH	MN
ST ELIZABETH HOSPITAL	WABASHA	MN
ST MARYS HOSPITAL	ROCHESTER	MN
FAIRVIEW REDWING HOSPITAL	RED WING	MN
COMMUNITY MEMORIAL HOSPITAL	WINONA	MN
ST LUKES HOSPITAL	DULUTH	MN
METHODIST HOSPITAL	ST LOUIS PARK	MN
HEALTH EAST MIDWAY HOSPITAL	ST PAUL	MN
ABBOTT NORTHWESTERN HOSPITAL	MINNEAPOLIS	MN
REGINA MEDICAL COMPLEX	HASTINGS	MN
ROCHESTER METHODIST HOSPITAL	ROCHESTER	MN
ST JOSEPH'S HOSPITAL	ST PAUL	MN
LAKEVIEW MEMORIAL HOSPITAL	STILLWATER	MN
FAIRVIEW UNIVERSITY	MINNEAPOLIS	MN
REGIONS HOSPITAL	ST PAUL	MN
PHILLIPS EYE INSTITUTE	MINNEAPOLIS	MN
HENNEPIN COUNTY MEDICAL CENTER	MINNEAPOLIS	MN
CHISAGO HEALTH SERVICES	CHISAGO CITY	MN
UNIVERSITY OF IOWA HOSPITALS	IOWA CITY	IA
HEALTH EAST ST JOHNS HOSPITAL	MAPLEWOOD	MN

APPENDIX: 10

EXAMPLE OF THE MEDICAID AMBULATORY/OUTPATIENT PROCEDURES

11977 Removal with reinsertion, implantable contraceptive capsules

Repair-Simple

12001 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less

12002 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm

12004 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm

12005 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.6 cm to 20.0 cm

12006 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 20.1 cm to 30.0 cm

12011 Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less

12013 Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm

12014 Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm

12015 Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm

12016 Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm

12017 Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm

12018 Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm

12020 Treatment of superficial wound dehiscence; simple closure

12021 Treatment of superficial wound dehiscence; with packing

Repair - Intermediate

12031 Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less

12032 Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.6 cm to 7.5 cm

12034 Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 7.6 cm to 12.5 cm

12035 Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 12.6 cm to 20.0 cm

12041 Layer closure of wounds of neck, hands, feet and/or external genitalia; cm or less

12042 Layer closure of wounds of neck, hands, feet and/or external genitalia; cm to 7.5 cm

12044 Layer closure of wounds of neck, hands, feet and/or external genitalia; cm to 12.5 cm

12045 Layer closure of wounds of neck, hands, feet and/or external genitalia; cm to 20.0 cm

12051 Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucou membranes; 2.5 cm or less

12052 Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucou membranes; 2.6 cm to 5.0 cm

12053 Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucou membranes; 5.1 cm to 7.5 cm

12054 Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucou membranes; 7.6 cm to 12.5 cm

12055 Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucou membranes; 12.6 cm to 20.0 cm

Repair - Complex

13100 Repair, complex, trunk; 1.1 cm to 2.5 cm

13101 Repair, complex, trunk; 2.6 cm to 7.5 cm

13120 Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm

APPENDIX: 11

MEDICAID UTILIZATION REVIEW PROCESS AND DECISION TREE

WISCONSIN MEDICAID

APPENDIX: 11

MEDICAID UTILIZATION REVIEW PROCESS

OBJECTIVE

Assure that care for which payment is made for services provided to Wisconsin Medicaid recipients is:

- Medically necessary
- Appropriate
- Timely
- Consistent with generally accepted standards of medical care

SCOPE

Any case selected for review where a Medicaid recipient was treated under fee-for-service and/or managed care.

PROCESS

RN Reviewer

An initial utilization review is performed by an RN reviewer who applies the appropriate Department-approved criteria. The set of criteria are designed to assess the medical necessity and appropriateness of an inpatient acute care hospital or skilled nursing facility (e.g., swing bed) admission.

Note: Criteria are used as a screening tool for the RNs performing case review. The criteria are not intended to constitute physician standards of care, but are solely for use as a screening tool for the RNs performing case review. Professional judgment is also applied when reviewing the medical record. If the RN identifies a potential utilization concern, she/he will forward the medical record along with a written summary of the case and the concern identified to a Contractor physician reviewer of like specialty.

If an admission is found to be medically unnecessary, the RN reviewer has the following two options:

- Override the RN screening criteria based upon professional judgement and complete the review.

  Note: RN review overrides are monitored by the VP of Review Services.

- Refer the case to a physician reviewer for peer review.

First Physician Review

All physician reviewers are board certified, engaged in the practice of medicine and/or osteopathy, and have active staff privileges in a Wisconsin hospital. Contractor matches the specialty and demographics (urban/rural) of the physician reviewer with the physician identified in the quality of care concern. Contractor maintains a file of physician names and specialties that are licensed to practice medicine in the State of Wisconsin. A list of demographics for each provider in the state of Wisconsin is also maintained by Contractor.

If the physician reviewer **does not uphold** the utilization concern, the case is returned to the RN reviewer for completion. The RN reviewer enters the case review findings into Contractor's online data entry system. The medical record is tracked to storage and retained for one year.

Note: The physician reviewer evaluates all aspects of the case to arrive at a review determination. Medical judgement is the controlling factor in deciding whether the care provided could have been safely and effectively provided on an outpatient basis. The physician reviewer documents his/her rationale on the physician reviewer assessment form.

If the physician reviewer **upholds** the utilization concern, the RN reviewer will draft a Notice of Potential Denial letter that is sent to the provider and the attending physician. The Contractor's medical director signs the Notice of Potential Denial letter.

The involved parties are given thirty (30) calendar days to respond in writing to the proposed denial. Contractor encourages a joint response from the facility and the physician.

Second Physician Review

Following the thirty (30) calendar day time frame, the medical record, previous review information, and any additional information submitted by the provider and/or attending physician is returned to the physician reviewer who performed the initial case review.

Note: If no further information is received, the potential determination becomes the final determination.

After review of the information, the physician reviewer shall determine if the denial is resolved or upheld. The physician reviewer documents his/her rationale on the physician reviewer assessment form.

If the denial is resolved, a Final Approval Determination letter is sent to the provider and the attending physician.

If the denial upheld, a Final Denial Determination letter is sent to the provider and the attending physician. This letter informs all parties of their right to request a reconsideration within sixty (60) days.

If a reconsideration is requested, Contractor arranges a time for the reconsideration. The provider may submit additional information for review prior to the reconsideration.

Note: The physician who makes a reconsideration determination is someone other than the physician who made the initial denial determination.

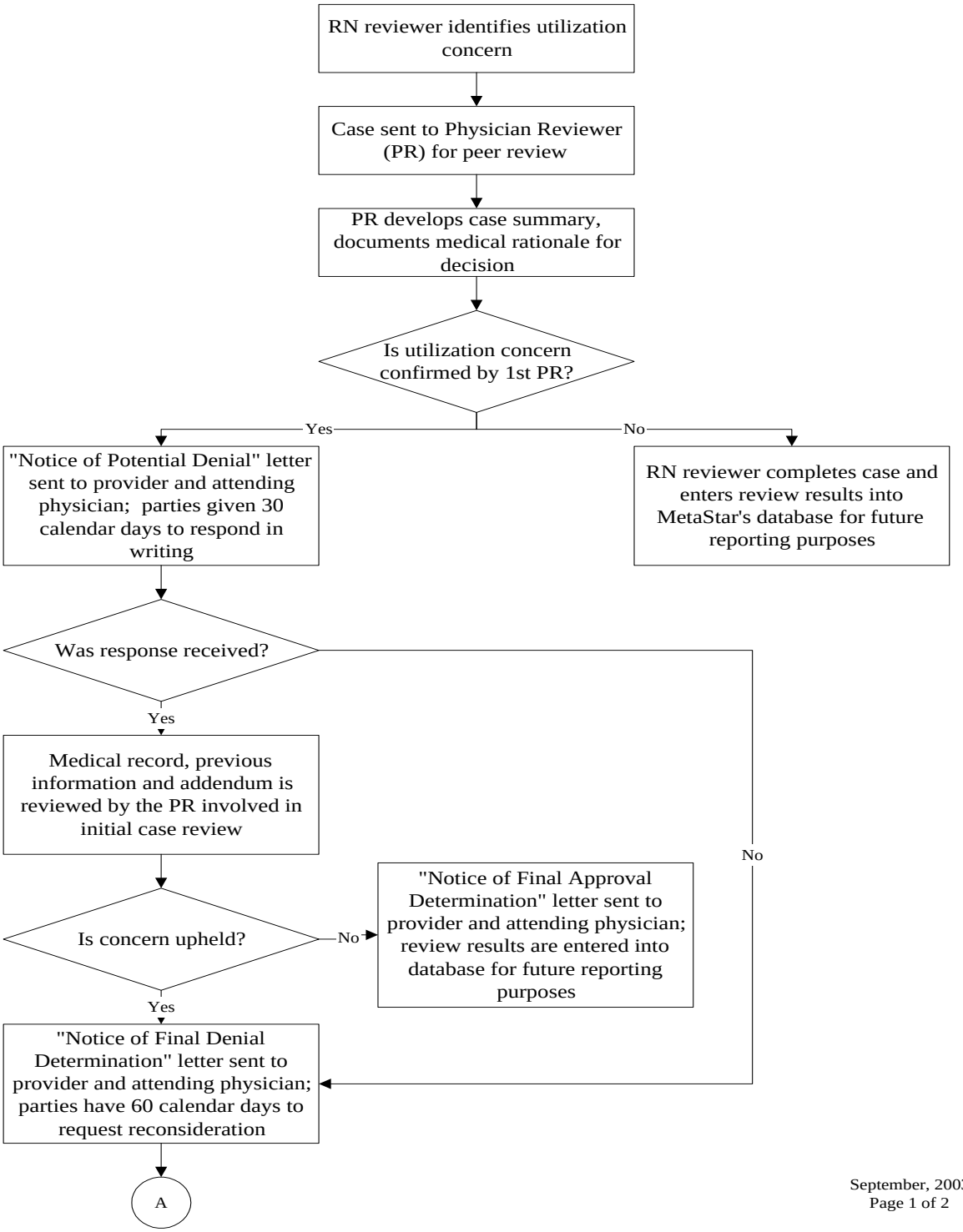
If the denial is overturned during the reconsideration process, the RN reviewer will complete the case.

If the denial is upheld as a result of the reconsideration process, a Final Reconsideration letter is sent to provider and the physician. The RN reviewer will complete the case and enter review results into Contractors database for future reporting to the DHCF.

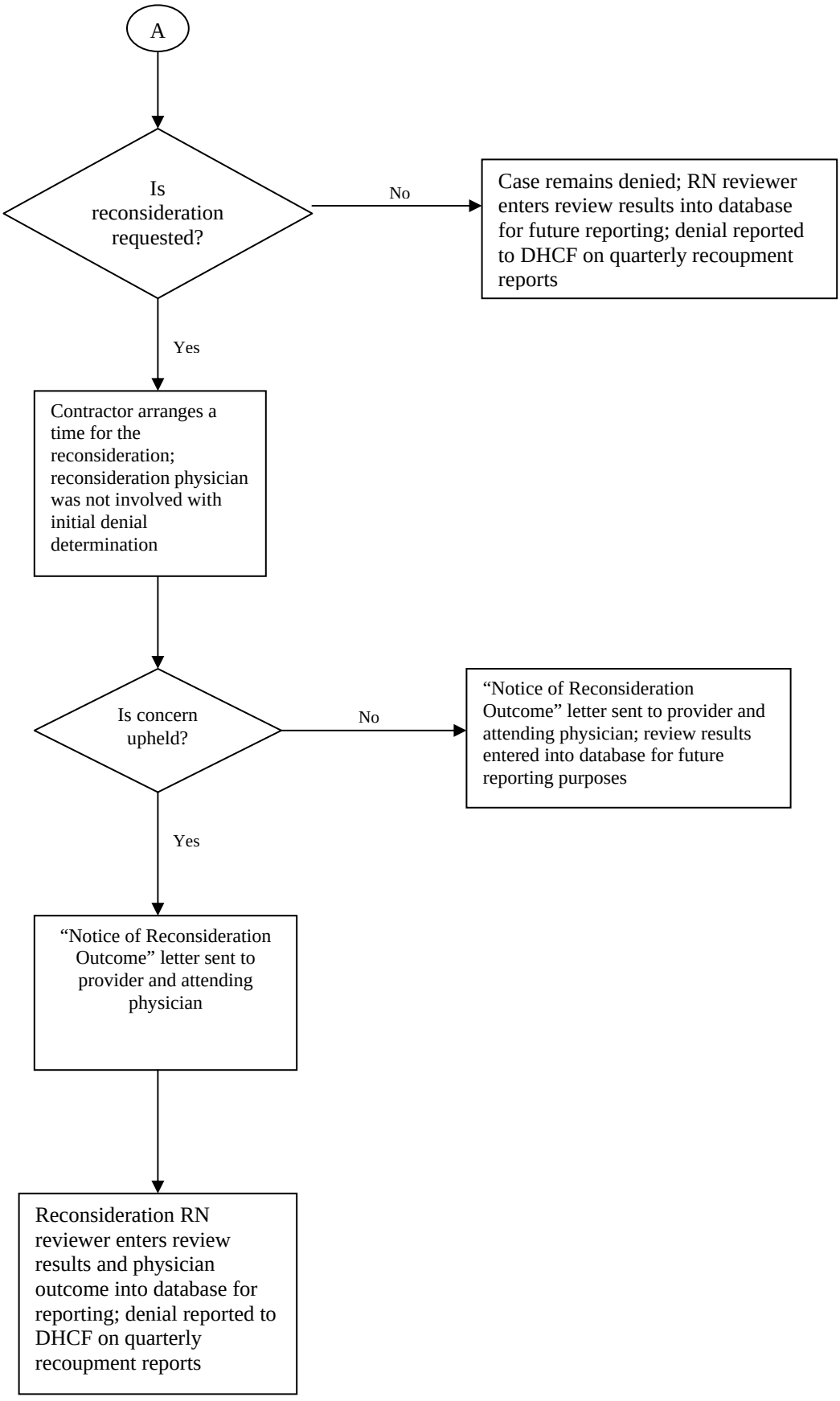
All denials are reported to the DHCF on a quarterly.

The Contractor shall provide a copy of the medical record and all documentation used in the review process including a narrative report clearly identifying the criteria failed and the utilization concern for each case upon request from DHCF.

Medicaid Utilization Review Process



September, 2003
Page 1 of 2


A
Is reconsideration requested?
No
Case remains denied; RN reviewer enters review results into database for future reporting; denial reported to DHCF on quarterly recoupment reports
Yes
Contractor arranges a time for the reconsideration; reconsideration physician was not involved with initial denial determination
Is concern upheld?
No
"Notice of Reconsideration Outcome" letter sent to provider and attending physician; review results entered into database for future reporting purposes
Yes
"Notice of Reconsideration Outcome" letter sent to provider and attending physician
Reconsideration RN reviewer enters review results and physician outcome into database for reporting; denial reported to DHCF on quarterly recoupment reports

APPENDIX: 12

READMISSION REVIEW METHOD

WISCONSIN MEDICAID

APPENDIX: 12

READMISSION REVIEW METHOD

I. PURPOSE

To determine the medical necessity and appropriateness of the readmission and to determine whether the readmission was the result of a premature discharge from the first admission.

For this review, "premature" means that the patient did not receive all acute care required or indicated for treatment of medical conditions and symptoms that existed during the hospitalization.

A patient/family initiated discharge is not considered premature.

II. PROCESS

A. The nurse review coordinator will verify case data and compare both admissions (first admission and subsequent readmission(s) occurring within thirty-one (31) days of discharge from a hospital) by reviewing patient symptoms and conditions plus the final principal and secondary diagnostic and procedural information for each case.

B. The Admission Review Criteria will be used to perform admission review on the first admission and subsequent readmissions to determine medical necessity and appropriateness of each case.

C. Using the review system discharge indicators, the nurse reviewer will perform discharge review.

D. The nurse reviewer will make an assessment of the quality of care.

E. The nurse reviewer will refer the case to a physician reviewer if any of the following determinations are made:

1. The admission(s) does not meet the Admission Review Criteria, or the nurse questions the appropriateness of the admission(s).

2. The review system discharge indicators were not met, or the nurse questions the appropriateness of the inpatient discharge from either admission.

3. The nurse reviewer questions the quality of care in either admission.

F. Based on review of the medical record, the physician reviewer will make the requested determinations regarding necessity, appropriateness, quality, and/or premature discharge.

G. Adverse findings of physician reviewer review relative to appropriateness and necessity will be handled through the denial process.

APPENDIX: 13

CONTRACTOR DENIAL PROCESS

WISCONSIN MEDICAID

APPENDIX: 13

CONTRACTOR DENIAL PROCESS

I. SCOPE

The Contractor will issue advisory payment denials in the following situations

A. Technical (administrative) Denials for:

1. Medical record not provided within required thirty (30) days.

2. Admission billed under wrong provider number.

3. Patient not actually admitted but claim filed.

4. One hospitalization billed as two or more.

B. Admission Denials resulting from physician advisor review:

1. Admission(s) found to be medically unnecessary.

2. Readmission within thirty-one (31) days of a premature discharge from the same hospital. (Payment denied for readmission.)

3. Inappropriate or unnecessary transfer from one hospital to another.

II. PROCESS

A. Technical Denials

Written notice of technical denials will be provided to the attending physician and hospital, with a copy to DHCF. Due to the nature of these denials, they are not subject to a proposed denial process that is intended to provide the physician/hospital with an opportunity to submit new information. These denials are, however, subject to reconsideration or reopening (for no medical record denials) if requested as specified in the denial notice.

B. Admission Denials resulting from physician advisor review

In the event a physician advisor makes a determination that would adversely affect reimbursement, Contractor will provide written notification of a proposed denial to the attending physician and the hospital. The Contractor will allow thirty (30) days for the hospital/physician to contact and discuss the proposed denial with a Contractor physician advisor. The physician advisor will make a final review determination following discussion of the case with the attending

physician and/or hospital physician representative, or following the thirty (30)-day deadline for physician input. Additional information to be considered in the final review determination must be submitted in writing in the form of an addendum.

If the physician advisor's final determination is to deny payment, a written denial notice will be provided to the attending physician, and the hospital (with a copy to DHCF). This denial notification will include the rationale for the decision as well as instructions on how to request a reconsideration of the decision.

APPENDIX: 14

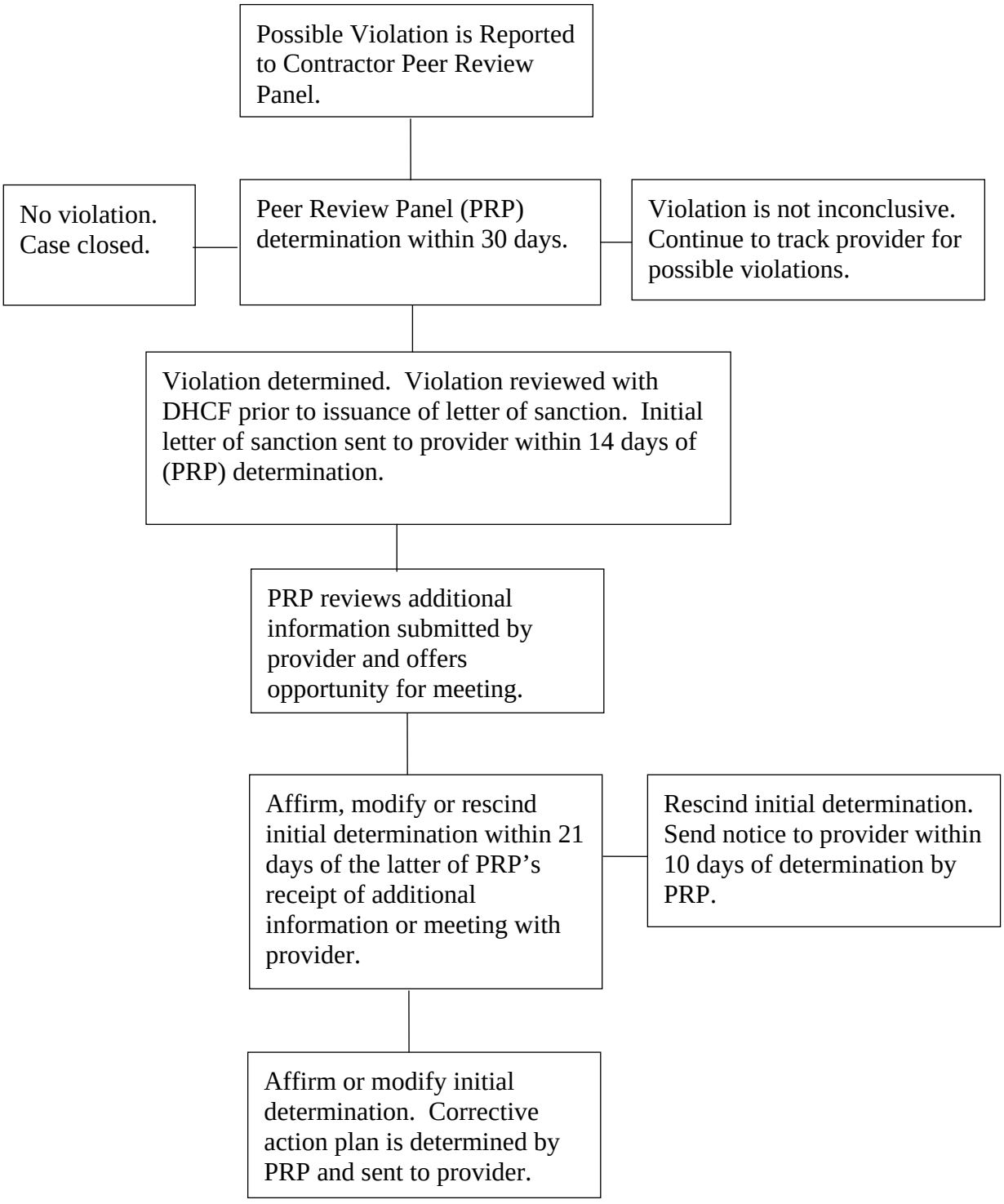
SANCTION PROCESS

WISCONSIN MEDICAID

APPENDIX: 14

SANCTION PROCESS

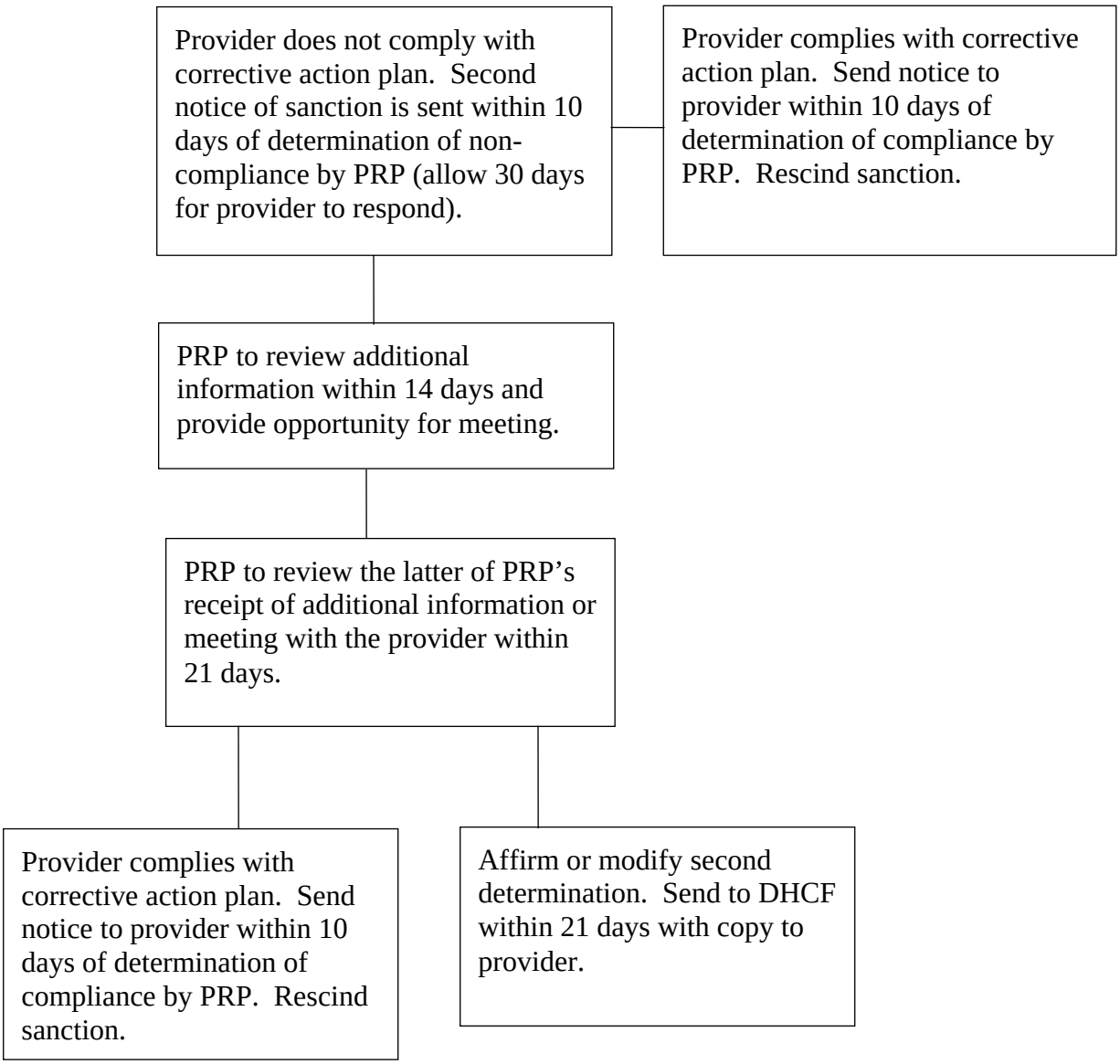
Possible Substantial Violation in a Substantial Number of Cases



WISCONSIN MEDICAID

Sanction Process - Substantial Violation

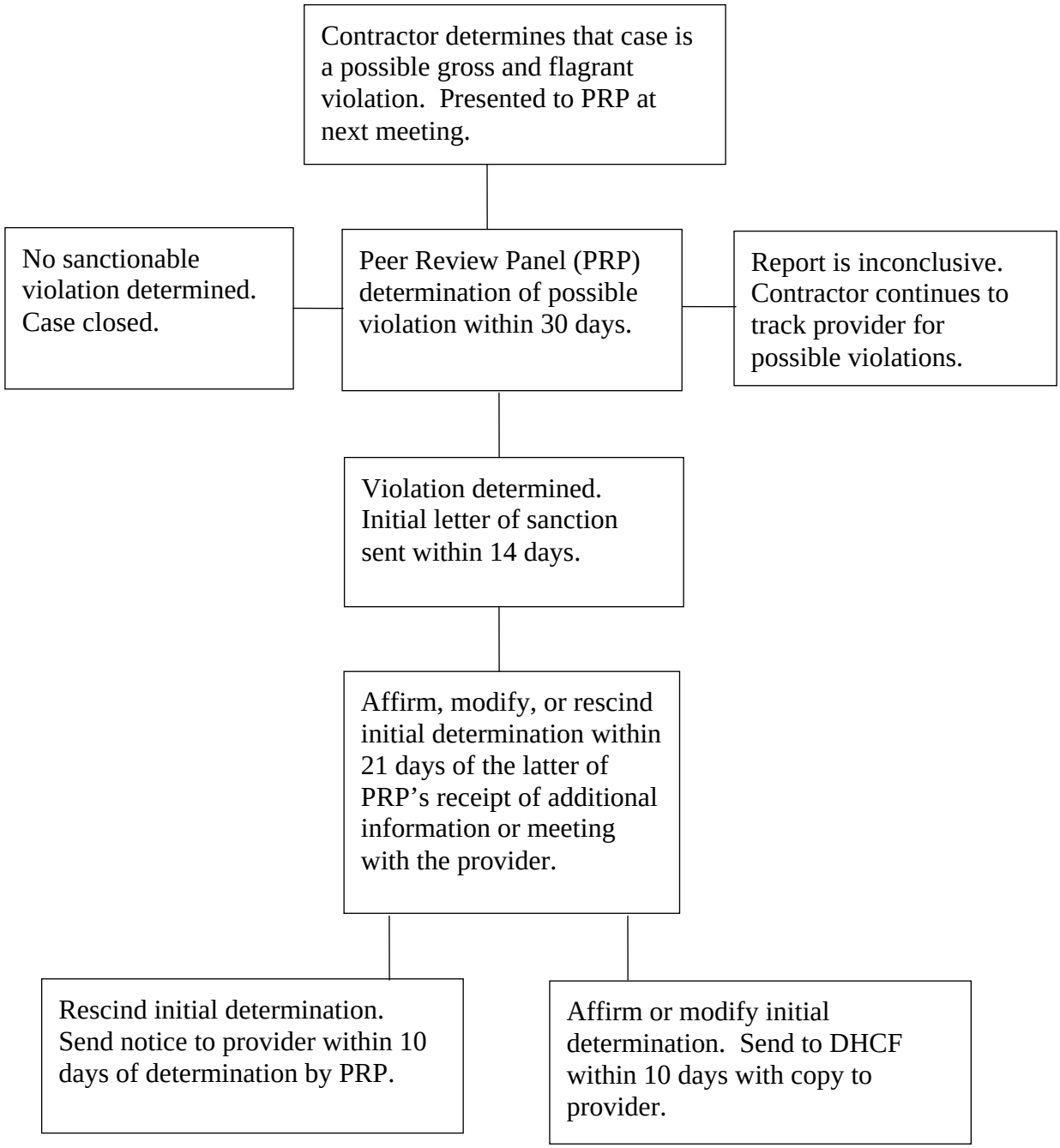
(Continued)



WISCONSIN MEDICAID

Sanction Process - Possible Gross and Flagrant Violation

(Continued)



NOTE: Contractor is expected to update DHCF throughout the sanction process and obtain DHCF agreement to proceed with process.

APPENDIX: 15

CONTRACTOR RECONSIDERATION PROCESS

WISCONSIN MEDICAID

APPENDIX: 15

CONTRACTOR RECONSIDERATION PROCESS

I. PROVISION AND APPLICABILITY

A provider or practitioner who is dissatisfied with the Contractor's denial determination that services furnished are not reasonable, necessary or delivered in the most appropriate setting, is entitled to a reconsideration by the Contractor.

II. REQUEST FOR RECONSIDERATION

A provider or practitioner that wishes to obtain a reconsideration must submit a written request to the manager of the appropriate Contractor review center.

The party who submitted a request to the Contractor may also withdraw it. This request must be in writing and received by the Contractor prior to the date the reconsideration meeting is held.

Upon receipt of the written request for reconsideration, the Contractor will arrange for a time and site of the reconsideration. Providers and practitioners will receive written notification of the reconsideration issue and meeting process when notified of the reconsideration date.

Reconsideration processing will include the following:

A. Teleconference and face to face reconsideration meetings will be chaired by the reconsideration physician. Since new information must be submitted ahead of time in the form of an addendum, oral discussions by attending physician(s) and/or hospital staff will be limited to ten minutes.

B. Total meeting time will be limited to 15 minutes and adherence to the issues and time limits will be monitored by the reconsideration physician. The Contractor staff will be available to assist if needed.

C. Once a reconsideration meeting has been scheduled, the Contractor will honor only one request to have the meeting rescheduled. An exception will be made only in the instance of a documented bonafide emergency.

III. QUALIFICATION OF RECONSIDERATION REVIEWER

A physician who makes a reconsideration determination must be qualified to make the initial determination and be someone other than the individual who made the initial determination and:

A. Is not related to the patient,
B. Has had no responsibility for the patient's care or treatment,

C. Has active admitting privileges in a least one hospital within the instate area,

D. Has no, or a member of his/her family (spouse, child, grandchild, parent or grandparent) has no ownership interest in the hospital that provided or proposed the service being considered,

E. Is a specialist in the type of services under review, except where meeting this requirement would compromise the effectiveness or efficiency of review, and

F. Is not associated with the initial determination.

IV. TIMING OF A REQUEST FOR RECONSIDERATION

A. Except for a request for expedited reconsideration of a preadmission denial determination, or a late request with good cause, a dissatisfied party must file a request for reconsideration within sixty (60) days after receipt of the notice of a denial determination.

B. The date of receipt of the notice of the denial determination is presumed to be five (5) days after the date on the notice, unless there is reasonable cause showing to the contrary.

C. A request is considered filed on the date it is postmarked.

D. The Contractor will accept a request filed after sixty (60) days after receipt of the notice of the denial determination if finds that there is good cause for the party's failure to file a timely request.

E. A request for an expedited reconsideration of a preadmission denial determination must be submitted within three (3) days after receipt of the denial determination.

V. GOOD CAUSE FOR A LATE FILING OF REQUEST FOR RECONSIDERATION OR HEARING

In determining whether a party has shown that it had good cause for not filing a timely request for reconsideration or hearing, the Contractor will consider:

A. What circumstances kept the party from making a request on time.

B. Whether an action by the Contractor misled the party.

C. Whether the party understood the requirements of submitting a request for reconsideration.

Examples of circumstances in which good cause may exist include, but are not limited to, the following situations:

A. Serious illness which prevented the party from requesting a reconsideration in person, through another persons, or in writing.

B. There was a death or serious illness in the party's immediate family.

C. Important records were accidentally destroyed or damaged by fire or other cause.

D. Other unusual or unavoidable circumstances exist that show that the party could not have known of the need to file timely or prevented the party from filing in a timely manner.

VI. OPPORTUNITY FOR A PARTY TO OBTAIN AND SUBMIT INFORMATION

At the request of a provider, or practitioner, the Contractor will provide an opportunity for examination of all the material upon which the determination was based. However, the Contractor will not furnish a provider, or practitioner with:

A. A record of the Contractor deliberations, or

B. The identity of the Contractor review coordinators, physician advisors, or consultant who assisted in the denial determination without their consent.

Contractor must provide a party with an opportunity to submit new information before the reconsideration determination is made. Additional information must be received within the established review time frames for submission of an addendum.

VII. EVIDENCE TO BE CONSIDERED BY THE RECONSIDERATION REVIEWER

A reconsideration determination will be limited to:

A. The information that led to the initial determination.

B. New information found in the medical records, or

C. Additional information submitted by a party.

VIII. FINAL DETERMINATION

Within fifteen (15) days of the Contractor reconsideration decision the Contractor shall send the provider and practitioner written notice of the final determination. This notice must contain the following:

A. Adequate information to allow Medicaid to locate the claim file,

B. The name of the Hospital, recipient, recipient Medicaid ID number, date of admission/discharge, and

C. The rationale for the reconsideration decision.

IX. RECORD OF FINAL DECISIONS

The Contractor will maintain a record of reconsiderations that include:

A. The basis for the denial determination,

B. Documentation of the date of the receipt of the request for reconsideration,

C. The detailed basis for the reconsideration determination,

D. Evidence supplied by the parties,

E. A copy of the notice of the proposed denial determination and the reconsideration determination that was delivered to the parties, and

F. Documentation of the delivery or mailing and, if appropriate the receipt of the notice of final reconsideration determination by the parties.

APPENDIX: 16

CONTRACTOR PROCESS
PAID CLAIMS PRE-RECOUPMENT PROCESS
NON-HMO INPATIENT HOSPITALIZATION

WISCONSIN MEDICAID

APPENDIX: 16

PAID CLAIMS PRE-RECOUPEMENT
NON-HMO INPATIENT HOSPITALIZATION
CONTRACTOR PROCESS

Audit Quarterly Disk Submission Process

- The Contractor will refer cases for recoupment to the Bureau of Health Care Program Integrity (BHCPI), Division of Health Care Financing (DHCF) on disk on a quarterly basis.

- Prior to sending the disk, the Contractor will ensure that the cases on the disk were not included on other disks in prior quarters. This would include:

  - Identifying cases that were submitted in prior quarters.

  - Identifying cases that have been approved or denied due to re-consideration or case re-opening.

- The Contractor will delete any cases that appear as duplicates from the new quarterly disk that were already included on prior disks.

Audit Pre-Recoupment Process

- The Contractor will provide recoupment reports to the BHCPI on disk on a quarterly basis.

- BHCPI will add the quarterly information to a MS Access database and create a table for each quarter.

- The BHCPI will combine the specified quarterly tables into one table to use to create recoupment reports to be sent to the provider.

- Prior to printing the reports, the BHCPI will send the table to the Contractor for review to identify those cases that have been reversed and approved due to re-con or case re-opening.

- BHCPI will delete the identified cases from the table and proceed to prepare preliminary findings and recoupment reports.

- BHCPI will send the table used to prepare the recoupment reports, to the Contractor to use as a guide to determine if cases should or should not be re-opened or re-considered. If a case appears in the table, then the Contractor will assume that recoupment has already been done or is in the process. The Contractor Shall not review the case unless otherwise notified by the BHCPI.

APPENDIX: 17

NON-HMO INPATIENT RETROSPECTIVE REVIEW SELECTION HIERARCHY

WISCONSIN MEDICAID

APPENDIX: 17

NON-HMO INPATIENT RETROSPECTIVE REVIEW SELECTION HIERARCHY
(Listed in Descending Order)

1.	Readmissions.	2,300
2.	Short stays including mental health admissions.	2,200
3.	Psychiatric admissions to acute medical/surgical hospitals for recipient ages >21 years.	1,000
4.	Quality physician focus review, including cases referred by DHFS.	<100

APPENDIX: 18

MEDICAID QUALITY REVIEW PROCESS

WISCONSIN MEDICAID

APPENDIX 18

MEDICAID QUALITY REVIEW PROCESS

When ever a Medicaid recipient's record is reviewed as part of the medical review process, Medicaid medical records are reviewed to determine if the services provided meet medically acceptable standards of care, are medically necessary, timely, and delivered in the most appropriate setting. To support continuous quality improvement in health care, DHCF has revised the quality review process. The scope of this review, its objectives, and the review process are explained below.

I. OBJECTIVES

- Assess if the care provided was medically necessary, reasonable, and appropriate for the diagnosis and condition of the recipient.
- Determine if the care provided meets professionally recognized standards of health care.
- Identify the source(s) of quality concerns.
- Determine the extent of problems in the delivery of care that warrant follow-up interventions.

II. SCOPE

A quality review is performed on all cases selected for review where a Medicaid recipient was treated under FFS, enrolled in a health maintenance organization (HMO), or enrolled in a special managed care organization (SMCO). (See Attachments 1 and 2). Annually, the EQRO Contractor provides the Division of Health Care Financing (DHCF) with a report and analysis of all review activities.

III. PROCESS: Inpatient and Ambulatory Quality Review

A. Registered Nurse (RN) Review

The (RN) reviewer performs an initial screening review of the medical record using appropriate screening instruments for each case to determine:

- If the documentation in the medical record is adequate to make a medical review determination (i.e. that all necessary reports and notes are present and legible).
- If the case requires referral to a physician reviewer.

For all cases, in addition to utilizing screening instruments designed for a particular review, the RN reviewer applies his/her own professional expertise to identify potential quality of care concerns for referral to a physician reviewer. If no quality concern is identified, the review results are entered into the EQRO Contractor's database and the case is closed.

If, during a review, the RN reviewer determines that a component of the medical record is missing or illegible, he/she will request the appropriate component from the provider.

- The provider is allowed fifteen (15) working days to submit the requested and/or additional documentation.

- If requested documentation is received, the case is reviewed and the review results are entered into EQRO Contractor's database.

- If the requested documentation is not received, the case will be technically denied and the denial results are entered into the EQRO Contractor's database for future analysis.

- Cases may be reopened and reviewed if the information is submitted at a later date.

Incomplete medical records that are identified during the review of HMO, SMCO, and FFS ambulatory care, will be reported to DHCF individually at the time each audit is completed.

B. Physician Review

All physician reviewers are board certified, engaged in the practice of medicine and/or osteopathy, and have active staff privileges in a Wisconsin hospital. The EQRO Contractor matches the specialty and demographics (urban/rural) of the physician reviewer with the physician identified in the quality of care concern. The EQRO maintains a file of physicians who are licensed to practice medicine in Wisconsin. A list of the specialties and demographics for each provider in Wisconsin is also maintained.

First Level Physician Review

The first level of physician review is performed for every case in which the RN reviewer has identified a potential concern requiring a clinical decision. The physician reviews the RN's written case summary, potential concern, and the complete medical record to determine:

- If the potential concern(s) identified and referred by the RN reviewer is supported by the documentation.

- If review of the medical record demonstrates additional concerns not identified by the RN reviewer.

If the first level physician reviewer determines that all concerns identified by the RN reviewer are resolved and does not identify additional potential concerns, the review results from the first level physician review are entered into EQRO Contractor's database and the case is closed.

If the first level physician reviewer determines that a potential concern exists, he/she assigns one of the following quality concern categories:

- Quality concern with the potential to cause an adverse outcome.
- Quality concern that caused an adverse outcome.

The physician reviewer also identifies the potential source(s) of the quality concern and documents the medical rationale for this determination on the physician reviewer form. The *source of quality concern* is the individual or department that provided the care that precipitated the quality concern.

Associate Medical Director Review

A physician associated with the EQRO reviews all potential concerns that have been identified by the first physician reviewer.

- If the associate medical director resolves the concern, the RN reviewer completes the case and enters the review results into the EQRO Contractor's database and the case is closed.

- If the associate medical director agrees with the first physician reviewer, a *Notice of Potential Concern* is sent to the physician(s) and provider, allowing them an opportunity to submit additional documentation. The involved parties are given thirty (30) calendar days to respond in writing to the potential concern. The EQRO encourages a joint response from the physician(s) and provider in order to complete the review in a timely manner and receive a comprehensive response to the potential quality concern.

Note: If a response is not received, the potential determination will be upheld as the final determination. (See Completion of Final Determination, page 4).

If a response is received, the medical record will be referred for a second level of physician review.

Second Level Physician Review

The second level physician reviewer may be the same physician reviewer that performed the initial review, or a consulting physician reviewer.

After review of all information, the physician reviewer determines if the concern is resolved or upheld.

If the concern is resolved, the physician reviewer documents his/her rationale on the physician reviewer referral form and the case is returned to the RN reviewer for completion. The EQRO will send a final approval letter to the parties involved and enter the review results into their database.

If the concern is upheld, the physician reviewer will also confirm the source(s) of the quality of care concern and document the medical rationale for his/her determination. If any additional source(s) of quality concern is identified, the newly identified source will receive a *Notice of Potential Concern* and be provided thirty (30) calendar days to respond, as outlined above.

C. Review Outcomes

For HMO and SMCO review, all cases with quality of care concerns are reported to DHCF in the respective review report at the completion of the audit.

In FFS review, if the upheld quality concern had the potential to cause an adverse outcome or caused an adverse outcome, the EQRO sends a Notice of Final Determination letter to all parties involved providing them with the opportunity to request a re-review within thirty (30) days if they disagree with the EQRO's determination**.**

D. Request for Re-Review

If the EQRO receives a written request for a re-review, a physician reviewer not involved in the initial review of the case will perform the quality re-review. This physician would be of the same specialty and same demographic area (urban/rural) as the one who received the final letter.

Note: If a response is not received, the determination set forth in the Notice of Final Determination letter will be upheld.

E. Completion of Final Re-Review Determinations

Concern Resolved

The EQRO sends a *Notice of Re-Review Determination* letter to all parties involved. The case is completed and the review results are entered into the database.

Upheld Quality Concern with the Potential to cause an Adverse Outcome.

The EQRO sends a *Notice of Re-Review Determination* letter to all parties involved. The upheld quality of care concern(s) is entered into a database for future analysis.

Annually, the EQRO performs profiling of the upheld quality of care concerns. Quality profiling would include analysis of confirmed quality concerns across Medicaid settings, including inpatient, ambulatory, and special managed care programs. When multiple concerns are identified for a physician and/or provider, the cases will presented to DHCF's chief medical officer for follow-up action, including, but not limited to, the following:

- Face-to face meeting between provider/physician and a physician associated with the EQRO.
- Corrective action plan
- Continuing education
- Referral to facility's quality committee
- Focused review of cases selected by physician, facility, diagnosis, and/or procedure codes, depending upon quality concern pattern identified. For example, if a pattern of quality concerns is identified for a specific physician related to the treatment of acute myocardial infarction (AMI), a focused physician review would include cases with a primary or secondary diagnosis of AMI.

Note: Focused review is not, in itself, a performance improvement activity, but rather a way to gather data to better understand patterns of quality of care concerns which may require performance improvement activities, or to monitor the results of performance improvement activities.

Upheld Quality Concern that caused an Adverse Outcome

Confirmed quality concerns that caused an adverse outcome are forwarded to DHCF's chief medical officer.

The EQRO Contractor will:

- Refer copies of the medical record and all documentation used in the review process to DHCF chief medical officer.

- Provide DHCF chief medical officer with a narrative report clearly identifying the criteria failed and quality of care concern for each case.

DHCF chief medical officer will:

- Review the entire case.

- Submit one of the following recommendations to the EQRO:

1. Refer case to the EQRO for further evaluation.
2. Uphold quality of care concern(s) and enter into the database for analysis.
3. Resolve quality of care concern.

The EQRO and DHCF will jointly send a *Notice of Re-Review Determination* letter to all parties involved.

F. EQRO Review Panel

A review panel provides a forum to objectively discuss quality concerns and provide physician-based recommendations for corrective and follow-up action.

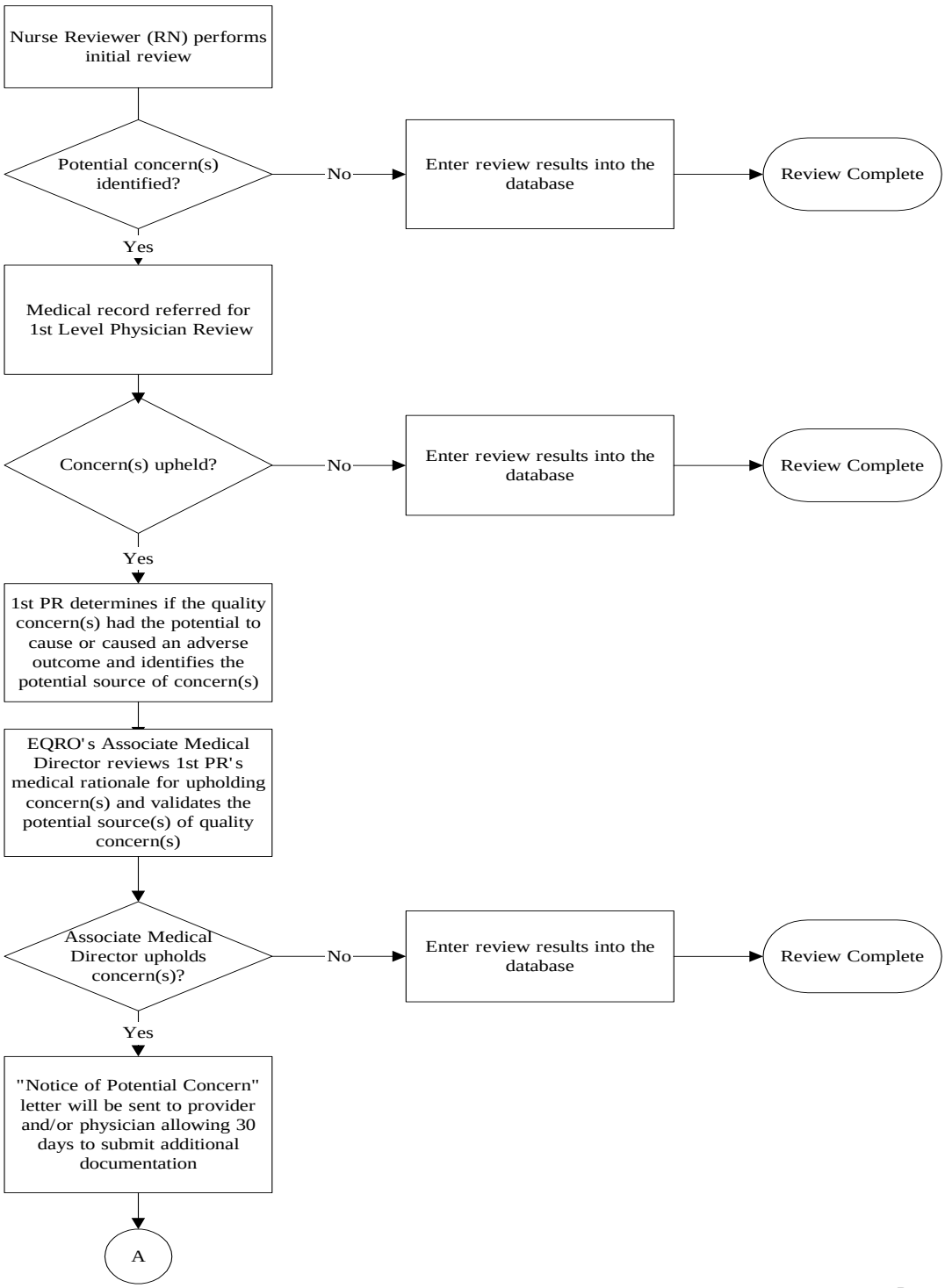
A review panel is comprised of seven practicing Wisconsin physicians from a variety of specialties and rural/urban locations. Members are knowledgeable about confidentiality and are provided with up-to-date information about the Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance standards and implementation schedule. Concerns about the performance of individual practitioners are not disclosed to educational bodies without the practitioner's written consent.

A review panel reviews the case and determines the appropriate course of follow-up action, including but not limited to the following:

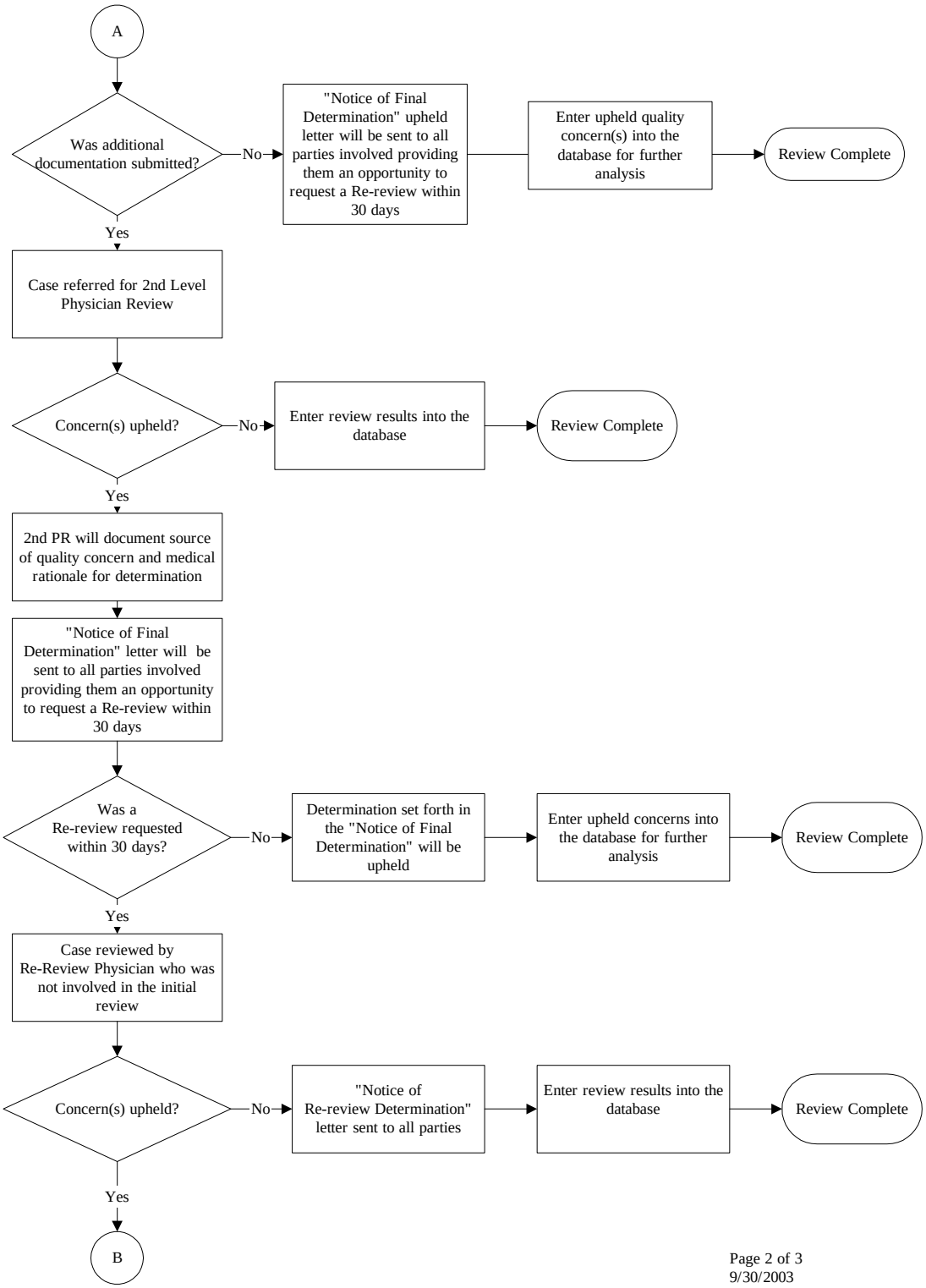
- Corrective action plan
- Continuing education
- Referral to facility's quality committee
- Referral to the State of Wisconsin Department of Regulation and Licensing
- No action necessary

The EQRO and DHCF will jointly send the final Panel determination letter to all parties involved. Review results will be entered into the database for analysis.

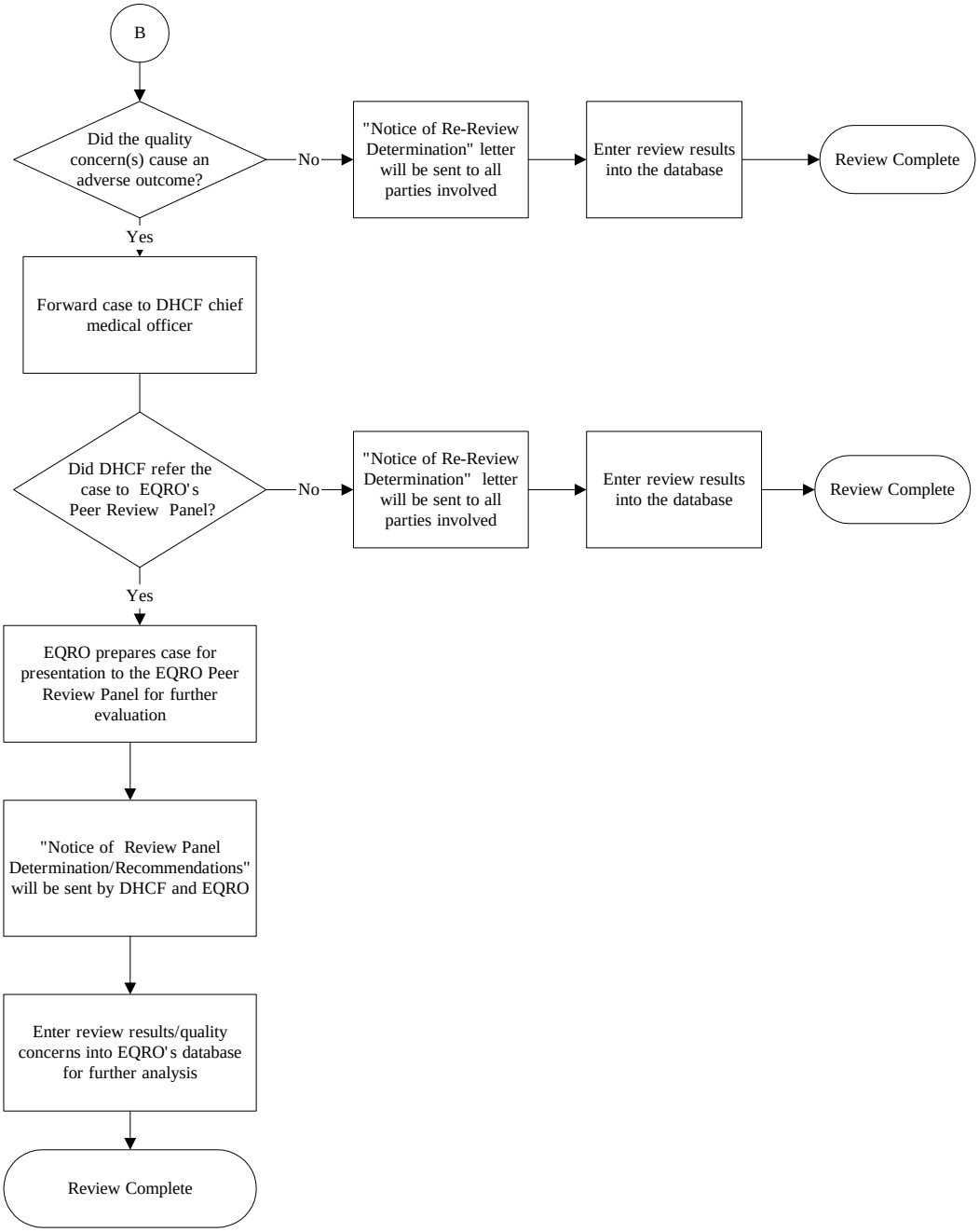
Attachment 1
Medicaid Inpatient & Ambulatory Quality Review Process Flowchart



Attachment 1
Medicaid Inpatient & Ambulatory Quality Review Process Flowchart



Attachment 1
Medicaid Inpatient & Ambulatory Quality Review Process Flowchart



APPENDIX: 19

DIRECTIVE MEMORANDUM TEMPLATE AND INSTRUCTIONS

WISCONSIN MEDICAID

APPENDIX: 19

DIRECTIVE MEMORANDUM -Template

DIRECTIVE #:

DATE: _____

TO: (name)_____
DHCF EQRO Contract Administrator

FROM: (name)_____

(position)_____

SUBJECT: _____

This memorandum directs the EQRO to do the following:

Purpose: _____

Delivery Date:_____

EQRO Requester and contact information:_____

EQRO Supervisor:_____

Attachments:_____

CC:_____

WISCONSIN MEDICAID

DIRECTIVE MEMORANDUM

INSTRUCTIONS

Directive #: The Contractor will assign an 8 digit code to the directive.

- The first four digits represent how many directives have been written that year.
- The next six digits are the date the directive is written.
- Examples:
  - ✓ The 27th directive written in 2005, on March 3rd is assigned: 0027-03/03/05.
  - ✓ The 154th directive written in 2007 on May 8th is assigned: 0154-05/08/07.

Date: The date the directive is submitted to the Department.

Subject: Briefly describe the change or area that the directive covers.

Purpose: Briefly describe the work product. Attach detailed specifications or a drawn mock up of the requested modification.

Delivery date: State the expected date of delivery.

Requester and contact information: Questions regarding the specifications are directed to the requester.

Supervisor: All EQRO Directives must be reviewed and signed by the responsible supervisor as designated by the EQRO for this purpose.

Attachments: Indicate how many attachments are included.

CC: This identifies who receives a copy of the directive.

In general:

The decision to initiate a directive can come from either the Department or the Contractor. The Contractor must prepare the directive and track the progress of the directive.

Deadlines, due dates, progress updates, etc, will vary and depend upon the needs of the projects/products described in the directive. These dates and scheduled updates must be described in the attached description of the directive specifications.

The Contractor will maintain a record of the directives and create a report summarizing the directives at the end of each Calendar Year. This report will be submitted to the DHCF contract administrator within 2 months following the end of the year. A short evaluation of the "directive" process along with suggestions for improving the process will accompany the year-end summary.

APPENDIX: 20

EXAMPLES OF QUALITY OF CARE REVIEW INSTRUMENTS

WISCONSIN MEDICAID

APPENDIX: 20

Recipient Name:_____

GENERIC MEDICAL RECORD REVIEW **Criteria Set #5**

	Approve	Fail	NA
1. Was the following baseline health status data recorded at the initial visit?			
a. Personal data (name, address, birth date, sex)	A☐	F☐	
a. Allergies or NKA	A☐	F☐	
b. Medications	A☐	F☐	
2. For each physician office visit, was the following recorded in the patient record?			
a. Chief complaint or purpose of visit	A☐	F☐	
b. History and physical findings	A☐	F☐	
c. Physician assessment	A☐	F☐	
d. Treatment plan	A☐	F☐	
e. Allergies	A☐	F☐	
f.Medications	A☐	F☐	
3. Diagnostic procedures and/or tests were performed or ordered in accordance with the patient's condition or clinical symptoms	A☐	F☐	NA☐
4. Abnormal test findings were addressed and followed up on	A☐	F☐	NA☐
5. If there are referral/consultation result documents in the record, are they initialed by the physician or were the referral/consultation recommendations addressed by the physician?	A☐	F☐	NA☐

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WISCONSIN MEDICAID

Recipient Name:_____

PRENATAL CARE – PNCC **Criteria Set #1**
(INCLUDING TEEN PREGNANCY)

	Approve	Fail	NA
1. Was there a positive pregnancy test at the time pregnancy was suspected **or** documentation of a positive pregnancy test performed elsewhere **or** was physical exam consistent with intrauterine pregnancy?	P☐	F☐	
2. Did initial prenatal evaluation include the following parameters?			
a. Complete history including: past pregnancies and outcomes, allergy, diabetes, hypertension, heart disease, immune disorder, kidney disease/UTI, neurologic disease, epilepsy (seizures), heptatitis, liver disease, phlebitis, thyroid dysfunction, pulmonary disease (TB, asthma), chickenpox, breast disease, abnormal Pap smear, surgery, blood transfusion, anesthetic complications, medications, tobacco use, alcohol use, illicit drug use, history of STD, GC, *Chlamydia*, HPV, syphilis, HIV, exposure to or history of genital herpes	P☐	F☐	
b. Complete physical exam including: weight, blood pressure, head, neck, teeth, thyroid, breasts, lungs, heart, abdomen, extremities, vulva, vagina, cervix, uterus (size), adnexa	P☐	F☐	
c. Were the following laboratory tests performed?			
1. ABO (blood type) and Rh factor	P☐	F☐	
2. Antibody screen	P☐	F☐	
3. Hemoglobin or hematocrit	P☐	F☐	
4. Rubella titer	P☐	F☐	
5. VDRL	P☐	F☐	
6. Pap smear	P☐	F☐	
7. Urinalysis	P☐	F☐	

	Approve	Fail	NA
8. Hepatitis B surface antigen	P☐	F☐	
9. HIV test (or declined)	P☐	F☐	
d. Genetic or metabolic disorder questionnaire			
1. Age 35 or older when baby is due	P☐	F☐	NA☐
2. Down's syndrome	P☐	F☐	
3. Spina bifida or neural tube defect	P☐	F☐	
4. Hemophilia	P☐	F☐	
5. Muscular dystrophy	P☐	F☐	
6. Cystic fibrosis	P☐	F☐	
7. Huntington chorea	P☐	F☐	
8. Phenylketonuria or PKU	P☐	F☐	
9. Mental retardation	P☐	F☐	
10. Three or more spontaneous losses of pregnancy (miscarriages)	P☐	F☐	NA☐
11. Tay-Sachs disease	P☐	F☐	
12. Sickle cell trait or disease	P☐	F☐	
13. Thalassemia	P☐	F☐	
e. Estimated date of confinement recorded or plans to determine an estimated date of confinement	P☐	F☐	
3. Are the following parameters recorded at each prenatal visit?			
a. Blood pressure	P☐	F☐	
b. Weight	P☐	F☐	
c. Fundal height (starting at 20 weeks gestation)	P☐	F☐	NA☐
d. Fetal heart tones (starting at 16 weeks gestation)	P☐	F☐	NA☐
e. Presentation (starting at 37 weeks gestation)	P☐	F☐	NA☐
4. Was there documentation of a treatment plan when high risk factors were identified?	P☐	F☐	NA☐
a. Were appropriate referrals made? (i.e., dietary, genetic counseling, social services, etc.)	P☐	F☐	NA☐
5. Is the primary physician clearly identified?	P☐	F☐	

WISCONSIN MEDICAID

Recipient Name:_____

WELL BABY/EARLY CHILD ASSESSMENT **Criteria Set #2**

Note: All criteria require age-appropriate assessments.

*** Criterion can be *Failed* by nurse reviewer without PR referral.**

	Approve	Fail	NA
1. Health, Nutritional, and Development Assessment			
a. Health History	P☐	F☐	NA☐
b. Nutritional assessment	P☐	F☐	
c. Health education/anticipatory guidance	P☐	F☐	
d. Developmental behavioral assessment	P☐	F☐	
2. Physical Assessment			
a. Physical exam performed (exam includes eyes, ears, skin, nose/throat, heart, lungs, and abdomen)	P☐	F☐	
b. BP	P☐	F☐*	
c. Measurement of height/length and weight	P☐	F☐	
d. Measurement of head circumference to 24 months of age	P☐	F☐	NA☐
e. Sexual development	P☐	F☐	
f. Assessment of hips to 2 years of age	P☐	F☐	NA☐
g. Assessment of gait: 12 months to two years of age	P☐	F☐	NA☐
3. Examination of Visual Acuity			
a. Visual screening completed (WMAP Handbook Appendix 15)	P☐	F☐	
4. Screening for Hearing Loss			
a. Hearing assessment completed (WMAP Handbook Appendix 14)	P☐	F☐	
5. Examination of Oral Health			
a. Oral assessment or referral to dentist	P☐	F☐	

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	Approve	Fail	NA
6. Immunizations: 0 to 24 months in age. Catch-up may take up to 4 years. Were the following immunizations given?			
a. First hepatitis B at birth to 2 months	P☐	F☐*	NA☐
b. First polio (OPV) at 2 months	P☐	F☐*	NA☐
c. First DtaP or DTP at 2 months	P☐	F☐*	NA☐
d. First H influenza type b (Hib) at 2 months	P☐	F☐*	NA☐
e. Second hepatitis B at 2 months or 4 months	P☐	F☐*	NA☐
f. Second polio (OP) at 4 months	P☐	F☐*	NA☐
g. Second DtaP or DTP at 4 months	P☐	F☐*	NA☐
h. Second Hib at 4 months	P☐	F☐*	NA☐
i. Third DtaP or DTP at 6 months	P☐	F☐*	NA☐
j. Third Hib at 6 months	P☐	F☐*	NA☐
k. Third polio at 6 months to 18 months	P☐	F☐*	NA☐
l. Third hepatitis B at 6 months to 18 months	P☐	F☐*	NA☐
m. First measles, mumps, and rubella (MMR) at 12 to 15 mos	P☐	F☐*	NA☐
n. Fourth Hib at 12 to 15 months	P☐	F☐*	NA☐
o. For Data Collection: First varicella (Var) at 12 to 18 months	P☐	F☐*	NA☐
p. Fourth DtaP or DTP at 15 to 18 months	P☐	F☐*	NA☐
7. 4 years of age and above			
a. Fifth DtaP or DTP at 4 to 6 years	P☐	F☐*	NA☐
b. Fourth polio at 4 to 6 years	P☐	F☐*	NA☐
c. Second MMR at 4 to 6 years	P☐	F☐*	NA☐
d. Second MMR at 11 – 12 years (if not already given)	P☐	F☐*	NA☐
c. Td at 11 – 16 years	P☐	F☐*	NA☐
f. Catch-up Hepatitis B at 11 – 12 years	P☐	F☐*	NA☐
g. For Data Collection: Catch-up Varicella at 11 – 12 years	P☐	F☐*	NA☐

	Approve	Fail	NA
8. Laboratory			
a. Blood lead level	P☐	F☐	
b. Hgb or Hct tested within first year	P☐	F☐	NA☐
c. If Hct <30 or Hgb <10.5, test was repeated	P☐	F☐	NA☐
d. Urinalysis if clinical signs and symptoms of UTI	P☐	F☐	NA☐
e. TB skin test performed if clinically indicated	P☐	F☐	NA☐
f. For African-American child, sickle cell test result recorded or ordered by 6 to 12 months of age	P☐	F☐	NA☐
9. If any abnormalities were identified during the exam, was a treatment plan developed?	P☐	F☐	NA☐

WISCONSIN MEDICAID

Recipient Name:_____

HEALTHCHECK **Criteria Set #35**

Note: All criteria require age-appropriate assessments

*** Criterion can be *Failed* by nurse reviewer without PR referral**

	Approve	Fail	NA
1. Health, Nutritional, and Development Assessment			
a. Health History	P☐	F☐	
b. Nutritional assessment	P☐	F☐	
c. Health education/anticipatory guidance	P☐	F☐	
d. Developmental behavioral assessment	P☐	F☐	
2. Physical Assessment			
a. Physical exam performed (exam includes eyes, ears, skin, nose/throat, heart, lungs, and abdomen)	P☐	F☐	
b. BP	P☐	F☐ *	NA☐
c. Measurement of height/length and weight	P☐	F☐	
d. Measurement of head circumference to 24 months of age	P☐	F☐	
e. Sexual development	P☐	F☐	
f. Assessment of hips to 2 years of age	P☐	F☐	NA☐
g. Assessment of gait: 12 months to two years of age	P☐	F☐	NA☐
3. Examination of Visual Acuity			
a. Visual screening completed (WMAP Handbook Appendix 15)	P☐	F☐	
4. Screening for Hearing Loss			
a. Hearing assessment completed (WMAP Handbook Appendix 14)	P☐	F☐	
5. Examination of Oral Health			
a. Oral assessment or referral to dentist	P☐	F☐	

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	Approve	Fail	NA
6. Immunizations: 0 to 24 months in age. Catch-up may take up to 4 years. Were the following immunizations given?			
a. First hepatitis B at birth to 2 months	P☐	F☐*	NA☐
b. First polio at 2 months	P☐	F☐*	NA☐
c. First DtaP or DTP at 2 months	P☐	F☐*	NA☐
d. First H influenza type b (Hib) at 2 months	P☐	F☐*	NA☐
e. Second hepatitis B at 2 months or 4 months	P☐	F☐*	NA☐
f. Second polio at 4 months	P☐	F☐*	NA☐
g. Second DtaP or DTP at 4 months	P☐	F☐*	NA☐
h. Second Hib at 4 months	P☐	F☐*	NA☐
i. Third DtaP or DTP at 6 months	P☐	F☐*	NA☐
j. Third Hib at 6 months	P☐	F☐*	NA☐
k. Third polio at 6 months to 18 months	P☐	F☐*	NA☐
l. Third hepatitis B at 6 months to 18 months	P☐	F☐*	NA☐
m. First measles, mumps, and rubella (MMR) at 12 to 15 mos	P☐	F☐*	NA☐
n. Fourth Hib at 12 to 15 months	P☐	F☐*	NA☐
o. First varicella (Var) at 12 to 18 months, for Data Collection	P☐	F☐*	NA☐
p. Fourth DtaP or DTP at 15 to 18 months	P☐	F☐*	NA☐
7. 4 years of age and above			
a. Fifth DtaP or DTP at 4 to 6 years	P☐	F☐*	NA☐
b. Fourth polio at 4 to 6 years	P☐	F☐*	NA☐
c. Second MMR at 4 to 6 years	P☐	F☐*	NA☐
d. Second MMR at 11 – 12 years (if not already given)	P☐	F☐*	NA☐
e. Td at 11 – 16 years	P☐	F☐*	NA☐
f. Catch-up Hepatitis B at 11 – 12 years	P☐	F☐*	NA☐
g. Catch-up Varicella at 11 – 12 years For Data Collection	P☐	F☐*	NA☐
8. Laboratory			
a. Blood lead level	P☐	F☐	

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APPENDIX: 21

QUALITY OF CARE
AMBULATORY SERVICES REVIEW
POTENTIAL REVIEW NUMBERS

WISCONSIN MEDICAID

APPENDIX: 21

QUALITY OF CARE AMBULATORY SERVICES REVIEW
POTENTIAL REVIEW NUMBERS

Depending upon the sampling needs and methodologies used, these numbers may vary and will be determined by the DHCF Chief Medical Officer.

Managed Care Organization (MCO) Ambulatory Quality of Care Reviews

13 HMOs 276 recipients per HMO

Fee for Service (FFS) Ambulatory Quality of Care Reviews

Wisconsin Counties 276 recipients

MCO Data Validity Audit Part II

13 HMOs 184 recipients per HMO

Special Managed Care Organization (SMCO)Quality of Care Reviews

I Care	140 recipients
*PACE/WPP	210 recipients
Elder Care	
CCE	
CHP	
CLA	
CCF	140 recipients
WAM	140 recipients

It is expected that the total number of medical record reviews may be higher secondarily to the number of hospital admissions or number emergency room visits. If possible, the sampling is to be done on the construct of "matched pairs" for institutionalization and emergency services.

*It had not been determined at the date of this RFB publication whether PACE/WPP (a group of four SMCOs) will be included in this External Quality Review Organization/Wisconsin Medicaid contract.

APPENDIX: 22

HMO PERFORMANCE IMPROVEMENT PROJECT EVALUATION TOOL

APPENDIX: 22
HMO PERFORMANCE IMPROVEMENT PROJECT EVALUATION TOOL

Standard	Question	Elaboration	Yes/No	Comments
III. TOPIC				
a. In order to be acceptable, the topic must be important.	Is the topic important?	The selected topic should be consistent with the goals of the managed care program. Topics typically address health or related issues (quality of life) that are highly prevalent in the served population, issues of low prevalence but of great consequence or an issue that needs obvious investigation because of some evidence. The topic might also reflect an identified priority of DHCF.		
b. In order to be acceptable, the topic must be useful	Is the topic one that can be affected by the HMO?	Is it likely that the QI study can be followed up by effective changes by the HMO or necessary?		
c. The importance of a topic is relative to all possible topics. A deliberate process to select topics from among all possible topics is the best assurance that the best topic was chosen.	Was the process by which the topic was chosen described and did this process evaluate competing topics?			
II. METHOD				
A. General				
1. In order to be acceptable, it must be clear what was done to address the topic.	Was the method and procedure used to study the topic clear?	If the study write-up was confusing, inconsistent or difficult to follow/understand answer no.		

Standard	Question	Elaboration	Yes/No	Comments
B. Study Questions				
1. In order to be acceptable, the topic must be refined in the form of a study question that is clear and consistent.	Was the study question- 1. Clearly stated and 2. Consistent throughout the study?	If the study question was clear and consistent throughout, answer "yes." If the study question was not stated (only inferred) was not clear, you had to hunt for it, piece it together, or it was not consistently stated or was inconsistent with what was actually done, answer "no."		
2. In order to be valid, the focus study must have a specific study question.	Was the study question specific?	A specific study question naturally leads to (implies) a method of measurement. A study question that is vague or too broad results in a poor focus study. Example of a specific study question: What is our rate of immunizations? A vague study question is are we providing good health care to our children?		
C. Population				
1. In order to assess usefulness and appropriateness, it must be clear who was studied.	Was the study population described on relevant variables such as age and sex?			
2. In order to assess external validity, the study must make it clear who was included in the study and who was excluded.	Were exclusion and inclusion criteria clear?	Do not consider eligibility (see below).		

Standard	Question	Elaboration	Yes/No	Comments
3. In order to be internally valid, a sufficient number of people must be studied. Results based on too few subjects cannot be accepted as accurate.	Were enough people studied?	If all qualified people were studied answer yes. If a subset of qualified people were studied, was the sample size adequate? Sample size is typically calculated using a "power analysis" evaluating risks for type I or type II error, or desired confidence limits. If the sample size is not obviously very large and it is not clear that the sample size was estimated or calculated using the constraints above, answer "no."		
4. If the study selected a subset of people from those who were qualified, obtaining valid results requires that subject selections be random.	If subject selection took place, was it random?	If there was no selection indicate "NA." If you can't tell if selection was random, or if it wasn't indicate "no."		
5. Eligibility is nearly always a relevant population variable for the Medicaid population. In order to assess generalizibility it must be addressed.	Was eligibility adequately addressed?	If eligibility was studied as a variable of interest (such as have immunization rates varied as a factor of eligible months) answer "yes." If eligibility was not restricted (in this case, the study might well discuss how this inclusion standard impacts expected results), answer "yes." If eligibility was restricted answer "yes" if the study noted how many of the subjects were lost due to this restriction and how this restriction may limit generalizibility.		

Standard	Question	Elaboration	Yes/No	Comments
D. Data Collection				
1. In order to assess acceptability, the data used to answer the study question must be fully described	Was the data fully described in detail?	Depending on the particular study, necessary elements include: specific codes used to operationalize some service or outcome, specific chart review questions or specific survey questions.		
2. In order to be valid, the data must be appropriate to answer the study question.	Was the data appropriate to answer the study question?	If the data was not appropriate, the comments should clearly explain why. If the data was not fully described (no above) answer no.		
3. In order to assess acceptability, the data collection process must be fully described	Was the data collection process fully described?	Depending on the particular study, necessary elements would include: the data system used to house administrative data, how queries were made to the database, how charts were requested and collected, how surveys were administered.		
4. In order to be valid, the data collected process must be appropriate to answer the study question.	Was the data collection appropriate to answer the study question?	If the data collection process was not appropriate the comments should clearly explain why. If the data collection process was not fully described ("no" above) answer "no."		

Standard	Question	Elaboration	Yes/No	Comments
5. Sometimes it is necessary to have at least one staff collect data. (Pulling administrative data is not considered here.) In order to be valid, data collectors must be appropriate, either by training or education, to the data collection task.	Were the data collectors appropriate to collect the data?	If training was necessary but not provided answer "no." If data collection required judgements and data collectors were not able to make those judgements either because they did not have the necessary education/experience background or because training was inadequate, answer "no" If training was not necessary, answer "NA"		
6. Sometimes it is necessary to have more than one staff member collect data. In this situation, reliability is a necessary condition for validity.	Was interrater reliability adequate?	If there was no data collectors (administrative data) answer "NA." If there was only one data collector, answer "NA." If there was more than one data collector and reliability was not measured answer "no." If reliability was measured but not adequate answer "no" and explain why it is inadequate under the comments section.		

Standard	Question	Elaboration	Yes/No	Comments
7. Some data or subjects are usually "lost" during the collection process. If this lost or missing data is significant, the study results cannot be generalized.	Did the loss of data or subjects threaten validity?	Answer "yes" if loss of data was not presented but should have been. Examples include: the number of charts requested, but not located, the number of surveys sent out but not returned; the number of providers or patients who refused to participate. Answer "yes" if the loss is reported and is so large so as to threaten generalizability. Explain your rationale for the decision in comments. Answer no if the reported data loss was minimal or if there was none expected (as may be the case with administrative data).		
E. Miscellaneous				
1. In order to assess acceptability, the study time period must be clearly stated.	Was the study time period clear?	This includes time spans for eligibility; time frame for services abstracted from charts or administrative data, and the time period of data collection itself. Examples of answering "no" include: not allowing reasonable time for the intervention to have an effect. The use of administrative data in a time frame without due consideration of claim lag, collecting data, in only part of the year in a project in which seasonality is apt to be important.		

Standard	Question	Elaboration	Yes/No	Comments
III. INTERVENTION: A focus study may have an intervention, the effect of which is measured on some outcome				
A. In order to evaluate study validity, the intervention must be fully described.	Was the intervention fully described?	The standard for "yes" is whether the intervention was described in enough detail to enable replication. Answer "NA" if there was no intervention		
B. Generalizability requires the intervention be practical, otherwise, even if it "works" it cannot be widely implemented.	Is the intervention practical (can it be widely implemented)? Answer "NA" if there was no intervention.			
C. In order to have confidence in the results, it must be clear that the intervention was implemented consistently and as intended.	Was the implementation of the intervention itself measured/observed and reported in order to ensure that it was done properly? Answer "NA" if there was no intervention.			
IV. RESULTS AND INTERPRETATION				
A. In order to assess acceptability, the collected data must be fully reported.	Was collected data fully reported?	If the study describes the collection of some data, which is not then described or is in some way used, answer "no."		

Standard	Question	Elaboration	Yes/No	Comments
B. In order to be useful, there must be some way to impart meaning into a result. Typically, this means comparing the measured results with some other number. This number may come from a guideline, or external goal. It could come from the result of a comparison group. It could come from a previous baseline measurement.	Did the study include a comparison in order to give the results meaning?			
C. A comparison to a norm or standard is possible only if that standard is expressed in a clear numerical fashion.	Is the norm or standard expressed in a specific numerical manner?	Respond "NA" if the study did not use a norm, goal or standard for comparison purposes.		
D. In order to be valid, the standard, goal, or norm must be appropriate to the population under study and data being collected.	Is the goal, norm or standard appropriate to this population and study?	Respond "NA" if the study did not use a norm, goal, standard for comparison purposes. If the standard might not apply to a Medicaid population, answer "no." If the standard was measured differently than in this study, answer "no."		

Standard	Question	Elaboration	Yes/No	Comments
E. If the results of a comparison group is used, in order to be valid, the comparison group must be as close or as similar as practical to the population under study. Differences must be acknowledged.	Was the comparison group as close as practical to the population under study and were differences acknowledged?	If a comparison group was not used, answer "NA." If the comparison group was not appropriate answer "no" and explain under comments. If differences between the comparison group and population were not acknowledged, answer "no."		
F. If the comparison as a pre-measure, is to, it is necessary, at a minimal, to consider whether other events might explain the differences between the pre and post measure.	Were possible explanation for the differences between pre and post measures considered?	If the study did not compare pre with post means, answer "NA."		
G. The comparison might be not with comparison group but with a true control group. In order to be valid, subjects must be randomly assigned to experimental and control groups	Was assignment to groups random?	If the study did not use a control group for comparison, answer "NA."		

Standard	Question	Elaboration	Yes/No	Comments
H. A comparison between two outcome numbers (standard vs. outcome, comparison group vs. population under study, pre vs. post, etc.) must account for random variation. This is accomplished by statistical tests of significance. Without statistical testing, differences between numbers cannot be accepted as real and true.	Did the appropriately study appropriately use statistical testing? (Confidence intervals, x^2, t-test, Regression analysis, etc.)	If there was no statistical testing, answer no and explain whether testing was possible under the comment section. Answer "no" if statistical testing was applied inappropriately or if there was a better statistical approach. Explain under comments.		
I. In order to be valid, the stated conclusions must be consistent with the results.	Were the conclusions consistent with the results?	If the data suggests a different conclusion or is equally supportive of conclusions in additions to those stated, answer "no."		
J. Many study write-ups include tables, graphs and figures. Such data displays must be consistent with the text.	Were data tables, figures, and graphs consistent with the text?	If the study did not include tables, graphs, and figures, answer "NA."		

Standard	Question	Elaboration	Yes/No	Comments
K. In order to be acceptable, the study should consider its limitations.	Did the study consider its limitations?	These limitations include, as appropriate, possible inappropriateness of standards used as comparison, possible alternative explanation of pre-post differences, incomparability of comparison groups, the limits on generalizability, effects of eligibility restraints, competing conclusions that are equally consistent with the data and basing conclusions on data collected over part of the year which might well not hold up during other parts of the year.		
L. Perhaps the most common source of invalidity in stated conclusions is "inferring causality from correlational data." Causality can be stated if when a true experiment is conducted, which is rare. Yet conclusions often imply that some intervention caused a particular result.	Did the study conclude or imply causality when the supporting data is only correlational?			
M. In order to be useful, the study should describe how the study could be improved.	Did the study include how to improve the study?			

Standard	Question	Elaboration	Yes/No	Comments
N. In order to be useful, the study should discuss what the results mean. What recommendations follow the results? What follow-up studies are suggested? What changes will be made based on the results?	Did the study present recommendations based on the results?			
V. MISCELLANEOUS				
	A. Was patient confidentiality protected?			
	B. Did consumers participate in the study (other than as subject)?			
	C. Did the study include some cost benefit analysis or some other consideration of cost savings?			
	D. Were the "next steps" described in detail (dates and timeliness)?			
	E. Were the results and conclusions distributed throughout the MCO?			

Standard	Question	Elaboration	Yes/No	Comments
	F. Did the tables, figures, and graphs "stand on their own" independent of the text?		If no table, graphs, and figures were used, answer "NA."	
	G. Did the study write-up include a succinct and accurate summary?			
	H. Was the study clear concisely and well written consistent with standard forms of study presentation?			

APPENDIX: 23

SPECIAL MANAGED CARE PROGRAMS
PERFORMANCE IMPROVEMENT PROJECT REPORT
REVIEW QUESTIONS

WISCONSIN MEDICAID

APPENDIX: 23

SPECIAL MANAGED CARE PROGRAMS
PERFORMANCE IMPROVEMENT PROJECT REPORT
REVIEW QUESTIONS

Answer the following 10 questions in narrative format. Attach tables, graphs, specifications, appendices as appropriate.

1. In a single sentence, state the question your study answers. Ideally, it should be stated in such a way that the data you collect and analyze provides an unequivocal answer.

2. Explain why you selected this topic. Consider whether you are studying a health condition that is prevalent in your patients. If it is not prevalent, is it important for some other reasons? These reasons might include a health condition of low prevalence but of very serious consequences; or a health condition that you have some reason to believe (from internal anecdotes or external literature) can be better managed. If you are studying some infrastructure feature (how referrals are processed, adequacy of transportation, etc.) rather than a particular health condition, please relate this feature to the health of your patients. Because resources available to do studies are limited, explain why you chose this topic rather than other possible worthy topics.

3. Describe the data you collected to answer the question. Include any data specifications you used. How was the data defined? In what ways was the data limited? If not everybody who could be studied was studied, how did you decide who was in the study and who was out? If eligibility criteria was used, why did you set the particular eligibility standard? How may potential patients were lost to the study because of this eligibility standard or other exclusion criteria?

4. Describe the data collection method. Where did the data come from? If data collection required expert or clinical judgment explain how you know the expert judgment was accurate. Consider issues such as the general professional training of the data collector, and specific training provided for data collection. If more than one person collected data and data collection required expert judgment, how do you know the data collectors made the same judgements?

5. Did you use some standard or norm to set expectations in your study? If yes, what standards were used? Were they from an external source such as a professional guideline or were they internal standards such as last year's performance? Explain why the standard you selected applies to your program, your study, and your patients?

6. What were your results? How did you relate your findings to any standard (if used) and to your study question? What "numbers" resulted from your study? If your study did not produce quantifiable measurements, please explain. Did your results lend themselves to statistical analysis? If yes, please explain the tests used and the meaning of their results. In a single statement, what answer does the data collected and analyzed make in answer to they study question? Is there any other ways to interpret the data? Please explain.

7. What were the limitations of your study? These may include any difficulties encountered as part of data collection or competing ways to interpret the findings. Consider if the conclusion applies to other programs, all your patients within your program, all your patients with a particular health condition or need, or only those patients you studied.

8. What would you do differently to study the same question next time?

9. What are the next steps, if any, to study this question/topic? What additional questions did your study raise?

10. What will you do differently as a result of your study?

APPENDIX: 24

CERTIFICATE OF NEED REVIEW
DECISION TREE AND NARRATIVE

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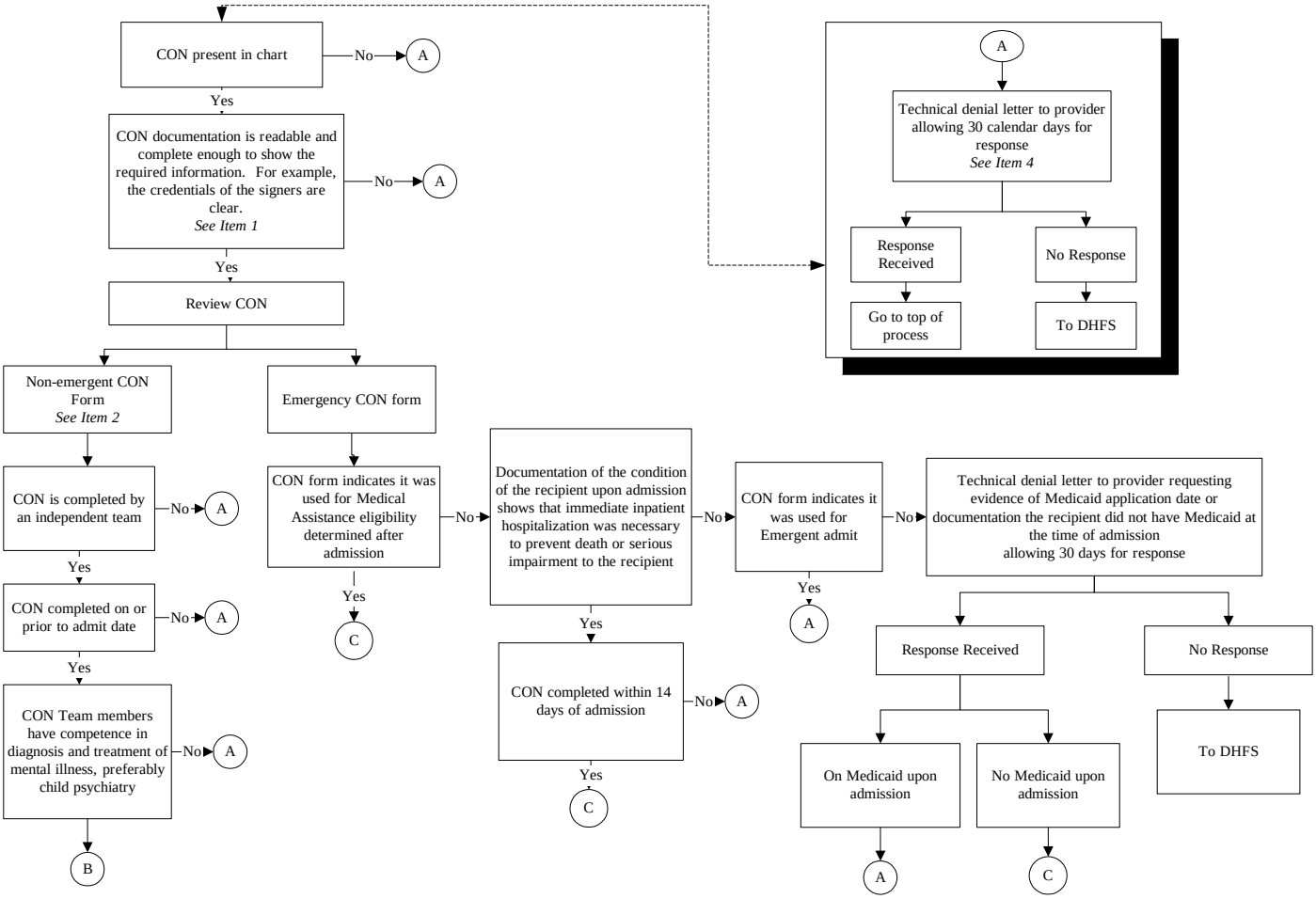
APPENDIX: 24

CERTIFICATE OF NEED REVIEW
DECISION TREE PAGE ONE

Decision Tree for Certificate of Need Review



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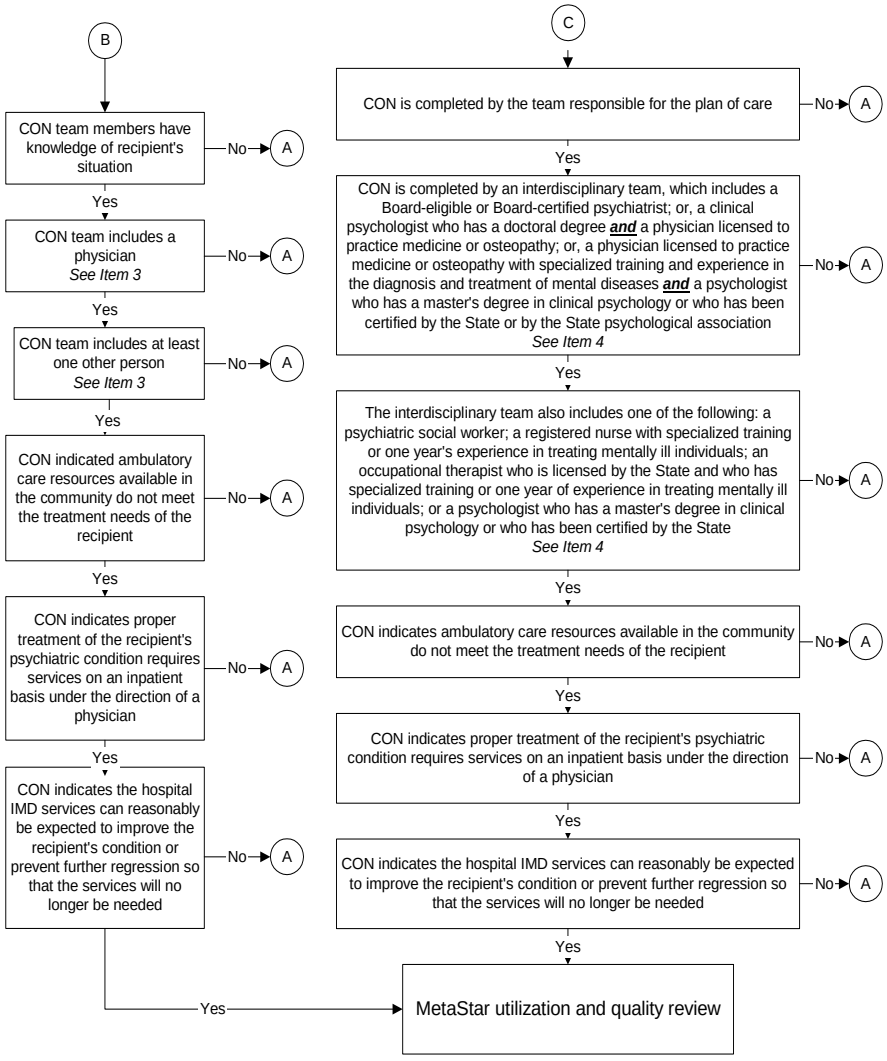
Page 1 of 2

Decision Tree for Certificate of Need Review (Page 2)



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APPENDIX: 24

CERTIFICATE OF NEED DECISION TREE NARRATIVE

Item I:

If the statements substantiating the CONs are not entirely legible due to poor quality facsimiles or photocopying, but the document is recognizable as a reproduction of a valid CON, Contractor may approve the CON as valid.

If a facility repeatedly includes illegible CON documents in their medical records, Contractor will send an advisory notice to the facility regarding the pattern of illegible CONS. If additional illegible CONS are received after the advisory notice, the Contractor will send a potential technical denial letter to the facility regarding the illegible CONs.

Item II:

If an Elective/Urgent CON is completed by the treating facility, but review of the medical record indicates that the circumstances of admission could be classified as an emergency, the Contractor will approve the CON provided it meets the requirements of completeness, timeliness and all other validity elements.

Item III:

A) Physician's Telephone Orders without a Counter-Signature on CON Document:

The Contractor will contact the treating facility's compliance officer or other appropriate hospital administrative person to obtain the facility's written policy on physicians countersigning telephone orders.

If the facility's policy requires a physician's counter-signature on a telephone order, the Contractor will issue a potential CON denial letter, giving the facility the opportunity to send the Contractor a corrected CON with the physician's counter-signature.

If the facility's policy does not require a physician's counter-signature on telephone orders, the Contractor will approve the CON without a counter-signature. The date of the telephone order will be accepted.

B) Signature Stamp:

The Contractor will contact the treating facility's compliance officer or other appropriate hospital administrative person to obtain the facility's written policy on the use of signature stamps.

If the facility's policy allows use of signature stamps on such documents as physician orders and/or physician progress notes, the Contractor will allow the use of a signature stamp on the CON.

If the policy does not allow the use of a signature stamp, the Contractor will issue a potential technical denial letter, giving the facility the opportunity to correct the CON. The physician or team member whose signature stamp was used may sign the CON form and return it to the Contractor. The original signature stamp date will be accepted.

APPENDIX: 25

TECHNICAL BID AND COST BID REVIEW CRITERIA CHECKLIST

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APPENDIX 25

TECHNICAL BID AND COST BID REVIEW
CRITERIA CHECKLIST

This checklist is for Department use to review the bids. The checklist is attached to the RFB # 0423-DHCF-SM for bidders who may want to use the criteria in preparation of their bids.

Reviewer:_____ Date:_____ BID #:_____

SECTION – CRITERIA	PRESENT	NOT PRESENT
SECTION 10		
External Quality Review Organization CMS designation (pg. 10-1)		
SECTION 20		
Completed Form DOA-3027 (pg. 20-4)		
Completed HIPAA Business Associate Form (pg. 20-4)		
Completed Form DOA-3070 (pg. 20-4)		
Completed Form DOA-3077 (pg. 20-4)		
Completed Form DOA-3078 (pg. 20-4)		
Conflict of interest Affidavit (pg. 20-6)		
SECTION 30 – GENERAL		
Guidelines followed in preparation of technical bid (pg.30-1)		
Technical bid sealed and under separate cover from cost (pg. 30-2)		
Technical and Cost bid received in DHCF by 2/11/04 (pg. 30-2)		
SECTION 30 - TECHNICAL BID		
Technical bid presented in required order (pg. 30-3)		
Transmittal letter present and contains statements regarding:		
Prime Contractor (pg. 30-3)		
Sole responsibility (pg. 30-3)		
No undue influence by Bidder (pg. 30-3)		
Affirmative Action Statement (pg. 30-4)		
Validity of Technical and Cost BID (pg. 30-4)		
No cost information (pg. 30-4)		
Bid authorized person (pg. 30-4)		
Inclusion of Wisconsin-specific features (pg. 30-4)		
No conflict of interest statement/affidavit(pg. 30-4)		
Written certification and authorization for access and examination of pertinent documents, etc. (pg. 30-4)		
Reduction/recoupment of payments (pg. 30-4)		
No arrangement/agreement with State or other Bidders (pg. 30-5)		
Statement regarding subcontractors (pg. 30-5)		
Cover pages present (pg. 30-5)		
Table of contents (pg. 30-5)		
Executive summary (pg. 30-5)		

Reviewer:_____ Date:_____ BID #:_____

SECTION – CRITERIA	PRESENT	NOT PRESENT
Assurance to execute and fulfill contract (pg. 30-6)		
Corporate capabilities (pg. 30-6)		
Capabilities description identified in time period July1, 2001 through June 30, 2000; for each health care review experience (eg. Medicare, Medicaid, Other) use the following criteria for each Experience and check type T18__ T19__ Other__		
Customer name and start/end dates		
Description of type of review		
Number of reviews for each type of review		
Description of pre-admission (inpatient) review process		
Review tools submitted for pre-admission process		
List of types of inpatient review screens/criteria		
Three examples of inpatient review screens/criteria		
List of types of ambulatory review screens/criteria		
Three examples of ambulatory review screens/criteria		
Description of process for review/evaluation/revision of inpatient and ambulatory screens/criteria		
Dates for latest update for inpatient and ambulatory screens/criteria		
Reasons for update for inpatient and ambulatory screens/criteria		
Description of all provider relation activities per contract		
Including topics, types of speakers, types of audiences		
Activities solely by Bidder or in conjunction with others		
Description of health care review data collection		
Description of health care review reporting		
Three examples of reports		
List of all lawsuits within past 5 years related to health care reviews with names of parties, nature of lawsuit, status/disposition		
Corporate information present (pg. 30-7)		
Date established		
Type of ownership		
Profit or non-profit status		
Total number of current employees		
For each health care review experience (eg. Medicare, Medicaid, Other) use the following criteria and check type T18__ T19__ Other__		
FTE assigned to professional physician review services		
FTE assigned to other professional (eg. RN, Therapy, etc)		
FTE assigned to analytical services		
FTE assigned to business information systems (BIS)		
FTE for data processing		
FTE for data management, including data validity		
FTE for programming		
FTE for data systems development		

Reviewer:_____ Date:_____ BID #:_____		
SECTION – CRITERIA	PRESENT	NOT PRESENT
FTE assigned to project services (eg. Provider relations activities, development of criteria/screens)		
Computer resources and extent dedicated for BIS		
Corporate financial statements for last 3 years(pg. 30-8)		
Corporate Financial Statements for last 3 years of each sub-contractor (pg. 30-8); if subcontractor identified mark the presence of financial statements subsection for each subcontractor;, identify by number		
Balance statements		
Statements of income		
Statements of change in financial position		
Notes to financial statement		
Auditors' reports and statements		
Bidder References (pg. 30-8)		
HCFA PRO Performance Evaluations for past 3 years		
List of references		
Health Care Review Staffing (pg. 30-8)		
Staffing levels for each major activity of the contract, includes identification of activities described in Part 3, Sections 70-120		
Section 70 Development of quality care tracking system		
Section 80 Telephonic pre-admission review		
Section 80 Inpatient reviews med/surg		
Section 90 CON reviews		
Section 100 Performance improvement measures		
Section 100 HMO ambulatory care reviews		
Section 100 Data validity audit		
Section 100 Performance improvement projects		
Section 110 FFS ambulatory care reviews		
Section 120 Special managed care reviews		
Identification of Key Personnel (pg. 30-8) number of key personnel may vary by bidder; specify bidder's number _____ and review for the following		
Name, title		
Resume has experience with health care review		
Responsibilities		
Percentage of time devoted to contract activities		
Organization chart with key personnel identified		
RN staffing plan for 7/04-6/05 (pg. 30-10) for the following areas with staff characteristics:		
Admission reviews		
Number (FTE)		
Description of clinical expertise		
Number (FTE) currently doing similar reviews		
Percentage of time devoted to activities		

Reviewer:_____ Date:_____ BID #:_____

SECTION – CRITERIA	PRESENT	NOT PRESENT
Delayed admission reviews		
Number (FTE)		
Description of clinical expertise		
Number (FTE) currently doing similar reviews		
Percentage of time devoted to activities		
Retrospective reviews		
Number (FTE)		
Description of clinical expertise		
Number (FTE) currently doing similar reviews		
Percentage of time devoted to activities		
DHCF referral reviews		
Number (FTE)		
Description of clinical expertise		
Number (FTE) currently doing similar reviews		
Percentage of time devoted to activities		
Mental health/substance abuse service reviews		
Number (FTE)		
Description of clinical expertise		
Number (FTE) currently doing similar reviews		
Percentage of time devoted to activities		
CON non-emergency admission reviews		
Number (FTE)		
Description of clinical expertise		
Number (FTE) currently doing similar reviews		
Percentage of time devoted to activities		
MCO focused provider reviews		
Number (FTE)		
Description of clinical expertise		
Number (FTE) currently doing similar reviews		
Percentage of time devoted to activities		
MCO performance improvement project reviews		
Number (FTE)		
Description of clinical expertise		
Number (FTE) currently doing similar reviews		
Percentage of time devoted to activities		
MCO medical record quality of care reviews		
Number (FTE)		
Description of clinical expertise		
Number (FTE) currently doing similar reviews		
Percentage of time devoted to activities		
MCO data validity reviews		

Reviewer:_____ Date:_____ BID #:_____		
SECTION – CRITERIA	PRESENT	NOT PRESENT
Number (FTE)		
Description of clinical expertise		
Number (FTE) currently doing similar reviews		
Percentage of time devoted to activities		
FFS retrospective reviews		
Number (FTE)		
Description of clinical expertise		
Number (FTE) currently doing similar reviews		
Percentage of time devoted to activities		
FFS focused provider reviews		
Number (FTE)		
Description of clinical expertise		
Number (FTE) currently doing similar reviews		
Percentage of time devoted to activities		
FFS chronic conditions reviews		
Number (FTE)		
Description of clinical expertise		
Number (FTE) currently doing similar reviews		
Percentage of time devoted to activities		
FFS targeted physician reviews		
Number (FTE)		
Description of clinical expertise		
Number (FTE) currently doing similar reviews		
Percentage of time devoted to activities		
FFS random sample reviews		
Number (FTE)		
Description of clinical expertise		
Number (FTE) currently doing similar reviews		
Percentage of time devoted to activities		
SMCO on-site reviews		
Number (FTE)		
Description of clinical expertise		
Number (FTE) currently doing similar reviews		
Percentage of time devoted to activities		
SMCO performance improvement reviews		
Number (FTE)		
Description of clinical expertise		
Number (FTE) currently doing similar reviews		
Percentage of time devoted to activities		
Description of reviewer performance standards (pg. 30-11)		
Detailed plan to assure uniform chart/project review (pg. 30-12)		

Reviewer:_____ Date:_____ BID #:_____

SECTION – CRITERIA	PRESENT	NOT PRESENT
Physician Reviewer plan is present (pg. 30-12) and contains		
Bidder currently has 20% of WI physicians (pg. 30-12)		
Or Detailed plan to obtain 20% of WI physicians (pg. 30-12)		
Detailed plan for performing reviews in 7/04-6/05 (pg. 30-12)		
Number physicians by specialty (pg. 30-12)		
Percentage of time available for reviews (pg. 30-12)		
Detailed plan for review, revision of review criteria (pg. 30-12)		
Detailed plan for assuring uniform chart review (pg. 30-12)		
Description of administrative processes which will support all review activities (pg. 30-12)		
Description of other available review personnel (pg. 30-13)		
Detailed plan for back personnel including (pg. 30-13)		
Key personnel		
RN staff		
Physician staff		
BIS staff		
Approach to implementation description present and contains		
Detailed description of take over approach (pg. 30-14)		
Implementation workplan (pg. 30-14) for 7/04-6/05 including		
Breakdown of all tasks, subtasks		
Calendar/schedule of tasks, subtasks		
Schedule of delivery reports, reviews		
CONTRACT MANAGEMENT (PG. 30-15) PRESENT AND INCLUDES		
Management tools for work flow		
Project/report status reporting		
Internal quality control		
Communications with Department		
Approach to Performance in Sections 80-120 (pg. 30-15);		
Section 80 Telephonic pre-admission review		
Objectives		
Tasks, subtasks		
Timeframes		
Final products		
Section 80 Inpatient reviews med/surg		
Objectives		
Tasks, subtasks		
Timeframes		
Final products		
Section 90 CON reviews		
Objectives		
Tasks, subtasks		

Reviewer:_____ Date:_____ BID #:_____		
SECTION – CRITERIA	PRESENT	NOT PRESENT
Timeframes		
Final products		
Section 100 Performance improvement measures		
Objectives		
Tasks, subtasks		
Timeframes		
Final products		
Section 100 HMO ambulatory care reviews		
Objectives		
Tasks, subtasks		
Timeframes		
Final products		
Section 100 Data validity		
Objectives		
Tasks, subtasks		
Timeframes		
Final products		
Section 100 Performance improvement projects		
Objectives		
Tasks, subtasks		
Timeframes		
Final products		
Section 110 FFS ambulatory care reviews		
Objectives		
Tasks, subtasks		
Timeframes		
Final products		
Section 120 Special managed care reviews		
Objectives		
Tasks, subtasks		
Timeframes		
Final products		
COMPUTER RESOURCES (PG. 30-16) PRESENT, INCLUDING		
Description of equipment		
Location of equipment		
Software capability		
Backup processing capabilities		
Ability to process data from Department's fiscal agent		
Description of Review Support/Support Systems (pg. 30-16)		
ASSESSMENT OF BIDDER STRENGTHS, COMMITMENTS, RISKS (PG. 30-17) INCLUDING		

WISCONSIN MEDICAID

Reviewer:_____ Date:_____ BID #:_____		
SECTION – CRITERIA	PRESENT	NOT PRESENT
Loss of review staff		
Loss of key personnel		
Failure to meet contract requirements		
Description of and Conformance to Standards (pg. 30-16)		
Description of knowledge of Medicaid program (pg. 30-17)		
National		
State		
Description of knowledge of current Medicaid (State) health care reviews to takeover and perform reviews (pg. 30-17)		
SECTION 30 - COST BID		
Guidelines followed in preparation of cost bid (pg. 30-1)		
Cost bid sealed and under separate cover from technical bid (pg. 30-2)		
Cost bid received in the DHCF office on 2/11/04 (pg. 30-2)		
Statement of binding of cost bid for 1 year after date of submission (pg. 30-18)		
Medicaid Health Care Review Cost Form (pg. 30-18)		
Review Time and Cost Report (pg. 30-18)		

APPENDIX: 26

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA") BUSINESS ASSOCIATE AGREEMENT

WISCONSIN MEDICAID

APPENDIX: 26

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA")

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (Agreement) supplements and is incorporated into the existing Underlying Contract (Contract) known as the [**Insert Contract Title**] covering the provision of [**Insert Description of Contracted Services]** entered into by and between [**Insert Legal Name of Business Associate**] (Business Associate) and [**Insert Legal Name of Covered Entity**] (Covered Entity) on [**Insert Agreement Signed Date**]. This Agreement is effective beginning on [**Insert Agreement Effective Date**] and terminates any prior existing Agreements.

This Agreement is specific to those services, activities, or functions covered in the Contract where it has been determined that the Business Associate is performing services, activities, or functions on behalf of the Covered Entity that are covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These services, activities, or functions include:

[**INSERT DESCRIPTION OF SERVICES, ACTIVITIES OR FUNCTIONS CONTRACTED FOR**]

The Covered Entity and Business Associate agree to modify the Contract to incorporate the terms of this Agreement and to comply with the requirements of HIPAA addressing confidentiality, security and the transmission of individually identifiable health information created, used or maintained by the Business Associate during the performance of the Contract and after the Contract is terminated. The Business Associate agrees that any conflict between provisions of the Contract and the Agreement will by governed by the terms of the Agreement.

1. DEFINITIONS

Protected Health Information (PHI) means:

Health information, including demographic information, created, received, maintained, or transmitted by the Business Associate, on behalf of the Covered Entity, where such information relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the payment for the provision of health care to an individual, that identifies the individual or provides a reasonable basis to believe that it can be used to identify an individual.

PHI excludes individually identifiable health information in education records covered by the Family Educational Rights and Privacy Act (FERPA) (*see* 20 U.S.C. 1232g, *et. seq.*) and employment records held by the Covered Entity in its role as employer.

Individual means:

The person who is the subject of protected health information.

Disclosure means:

The release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

Designated Record Set means:

a. A group of records maintained by or for a covered entity that is:

(i) The medical records and billing records about individuals maintained by or for a covered health care provider;

(ii) The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or

(iii) Used, in whole or in part, by or for the covered entity to make decisions about individuals.

b. For purposes of this Agreement, the term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.

2. PROHIBITION ON UNAUTHORIZED USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Business Associate shall not use or disclose any PHI except as permitted or required by the Contract or this Agreement, as permitted or required by law, or as otherwise authorized in writing by the Covered Entity.

3. PERMITTED USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Business Associate may use or disclose PHI only for the following purpose(s):

a. for the delivery of the services, program management, activities, or functions contracted for in the Contract; or

b. for meeting contractual or legal obligations as established in any agreements between the parties evidencing their business relationship; or

c. as permitted by HIPAA if such use or disclosure were made by the Covered Entity or otherwise required by applicable law, rule or regulation; or

d. for use in the operations of the Business Associate as provided in paragraph 4 of this Agreement; or

e. as otherwise authorized by the Covered Entity in writing; or

f. data aggregation for the health care operations of the Covered Entity.

4. USE OF PROTECTED HEALTH INFORMATION IN BUSINESS ASSOCIATE OPERATIONS

The Business Associate may use or disclose PHI as necessary for the delivery of the services or programs provided for in the Agreement, including appropriate management and administration of programs or services, or to fulfill the contractual or legal obligations of the Business Associate provided:

a. the disclosure is permitted or required by law; or

b. the Business Associate obtains reasonable assurances, evidenced by a written contract, from any person or organization to which the Business Associate will disclose PHI that such person or organization shall:

(i) hold all PHI in confidence and use or further disclose it only for the purpose for which the Business Associate disclosed it to the person or organization, or as required by law; and

(ii) notify the Business Associate, who will in turn promptly notify the Covered Entity, of any instance that the person or organization becomes aware of in which PHI was improperly disclosed.

5. SAFEGUARDING AND MAINTENANCE OF PROTECTED HEALTH INFORMATION

a. The Business Associate will develop, implement, maintain, and use:

(i) appropriate administrative, technical, and physical safeguards to prevent improper use or disclosure of PHI, in any form or media; and

(ii) appropriate administrative, technical, and physical security measures to preserve the confidentiality, integrity and availability of electronically maintained or transmitted PHI.

b. The Business Associate will document and keep these safeguards and security measures current and available for inspection by the Covered Entity or its agents, upon request. Security measures employed by the Business Associate must comply with HIPAA security requirements on or before the date such requirements become effective.

6. USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION BY SUBCONTRACTORS AND AGENTS OF THE BUSINESS ASSOCIATE

The Business Associate agrees to require any agent, including subcontractors, to whom the Business Associate provides PHI to comply with the same restrictions and conditions applicable to the Business Associate with respect to PHI. This provision does not apply to the use or disclosure of PHI by subcontractors that provide health care treatment to individuals or to other persons or organizations that have entered into an Organized Health Care Arrangement (OHCA) as provided for under the provisions of HIPAA.

7. COMPLIANCE WITH ELECTRONIC TRANSACTIONS AND CODE SET REGULATIONS

If the Business Associate conducts any HIPAA-covered standard electronic transaction(s) on behalf of the Covered Entity, the Business Associate will comply with the applicable provisions of HIPAA for such standard transaction(s). The Business Associate will likewise require any subcontractor or agent conducting any standard electronic transaction(s) on behalf of the Business Associate, for services or programs covered by the Contract, to comply with the applicable provisions of HIPAA relating to standard transactions.

a. General requirements.

(i) If any entity requests the Business Associate to conduct any of the standard electronic transactions, the Business Associate must comply with the request.

(ii) The Business Associate may not delay or reject a transaction, or otherwise adversely affect or impact the other entity or the transaction submitted, because the transaction is a standard electronic transaction.

(iii) The Business Associate may not reject a standard electronic transaction on the basis that it contains data elements not needed or used by the Business Associate (e.g., coordination of benefits information).

(iv) The Business Associate may not offer an incentive to a health care provider to conduct a covered transaction through direct data entry (as described in CFR 45 §162.923(b)) rather than as a standard electronic transaction.

(v) Business Associates operating as a health care clearinghouse, or requiring an entity to use a health care clearinghouse to receive, process, or transmit standard electronic transactions may not charge fees or impose costs in excess of the fees or costs for normal telecommunications that the entity incurs when it directly transmits, or receives, a standard electronic transaction to, or from, the Business Associate.

b. The Business Associate will not enter into, or permit its subcontractors or agents to enter into, any agreement related to the conducting of standard electronic transactions for or on behalf of the Covered Entity that:

(i) changes or modifies the definition, data condition, or use of a data element or segment in an implementation specification; or

(ii) adds any data elements or segments to the maximum defined data set; or

(iii) uses any code or data elements that are marked "not used" in the implementation specification or are not contained within the implementation specification; or

(iv) changes the meaning or intent of any implementations specification.

c. If the Business Associate receives a standard electronic transaction and coordinates benefits with another health plan, it must store the coordination of benefits data it needs to forward the standard electronic transaction to the other health plan.

8. ACCESS TO PROTECTED HEALTH INFORMATION

At the request of the Covered Entity, the Business Associate agrees to provide access to PHI held by the Business Associate that the Covered Entity has determined to be part of the Designated Record Sets of the programs covered by the Agreement. Access to PHI will be provided to the Covered Entity or to an Individual as directed by the Covered Entity to comply with applicable HIPAA requirements. The Covered Entity may delegate responsibility for the performance of all legal obligations, including HIPAA rights, relating to the Designated Record Set to the Business Associate.

9. AMENDMENT OR CORRECTION TO PROTECTED HEALTH INFORMATION

At the direction of the Covered Entity, the Business Associate agrees to amend or correct PHI that the Covered Entity determines is included in the Designated Record Set held by the Business Associate. The Business Associate agrees that any amendment or correction will be completed by the Business Associate in accordance with applicable HIPAA provisions.

10. REPORTING OF UNAUTHORIZED USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Business Associate will inform the Covered Entity of any use or disclosure of PHI not authorized by this Agreement or in writing by the Covered Entity within [**Insert Number of Days**] business days of becoming aware of such use or disclosure. The Covered Entity, at its discretion, may require a written report. If a written report is requested by the Covered Entity, the Business Associate agrees to forward a written report to the Covered Entity not more than [**Insert Number of Days**] business days after

such request is made. Written and verbal reports of unauthorized use or disclosure will include:

a. A description of the circumstances of the unauthorized use or disclosure;

b. the PHI used or disclosed;

c. the person or persons making the unauthorized disclosure;

d. the person, persons or organization that received the unauthorized disclosure;

e. what actions the Business Associate has undertaken or will undertake to mitigate any harmful effect of the unauthorized use or disclosure; and

f. the actions the Business Associate has taken or will take to prevent future similar unauthorized uses or disclosures.

11. MITIGATING EFFECT OF UNAUTHORIZED DISCLOSURES OR MISUSE OF PROTECTED HEALTH INFORMATION

The Business Associate agrees to mitigate, to the extent practicable, any harmful effect known to the Business Associate created by an improper use or disclosure of PHI by the Business Associate in violation of the requirements of this Agreement.

12. TRACKING AND ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION BY THE BUSINESS ASSOCIATE

a. The Business Associate agrees to track disclosures of PHI as required by the applicable provisions of HIPAA. Specifically, the Business Associate agrees that it will maintain a record of all PHI disclosures made to third parties. The Business Associate agrees that the following information will be recorded:

   (i) the date the PHI was disclosed;

   (ii) the name and address, if known, of the person or entity that the PHI was disclosed to;

   (iii) a brief description of the PHI disclosed; and

   (iv) a brief statement describing the purpose for the disclosure.

b. For repetitive disclosures that the Business Associate makes to the same person or entity for a single purpose, the Business Associate will provide:

   (i) the disclosure information as specified in Paragraph 12(a)(i-iv) of this Agreement for the first of such repetitive disclosures;

   (ii) the frequency, periodicity or number of such repetitive disclosures; and

   (iii) the date of the most recent of such repetitive disclosures.

c. The Business Associate will make the record of disclosures available to the Covered Entity within [**Insert Number of Days**] business days after receiving a request by the Covered Entity.

d. Exceptions from Disclosure Tracking.

The Business Associate is not required to track or record disclosures of PHI, or to provide an accounting of disclosures for PHI meeting the following conditions:

(i) disclosures of PHI that are permitted under this Agreement, or otherwise expressly authorized by the Covered Entity in writing; and

(ii) disclosures of PHI for the following:

(1) for purposes of treatment, payment or health care operations activity of the Covered Entity;

(2) in response to a request from an Individual who is the subject of the disclosed PHI, or to that Individual's Personal Representative;

(3) made to persons involved in health care or payment for health care of the Individual;

(4) for disaster relief notification purposes;

(5) for national security or intelligence purposes; or,

(6) to law enforcement officials or correctional institutions regarding Individuals in custodial situations.

e. Disclosure Tracking Time Periods.

Business Associate agrees to maintain and make available to the Covered Entity upon its request information on disclosures of PHI made by the Business Associate for the six-year period preceding the request, but not including disclosures made prior to April 14, 2003, or the date that the Business Associate began performing covered services, activities, or functions on behalf of the Covered Entity, whichever is later.

13. ACCOUNTING TO THE COVERED ENTITY AND TO GOVERNMENT AGENCIES

The Business Associate agrees to make its internal practices, books, and records relating to the use and disclosure of PHI available to the Covered Entity, or to the Secretary of Health and Human Services (HHS) in a time and manner determined by the Covered Entity or the Secretary or designee, for purposes of determining compliance by the Covered Entity with the requirements of HIPAA. Further, the Business Associate agrees to promptly notify the Covered Entity of communications with HHS regarding PHI and

will provide the Covered Entity with copies of any PHI or other information the Business Associate has made available to HHS under this provision.

14. TERM AND TERMINATION OF AGREEMENT

a. The Business Associate and Covered Entity agree that this Agreement becomes effective on **[Insert Effective Date]**.

b. The Business Associate agrees that if in good faith the Covered Entity determines that the Business Associate has materially breached any of its obligations under this Agreement, the Covered Entity at its discretion, has the right to:

(i) exercise any of its rights to reports, access and inspection under this Agreement, and, or

(ii) require the Business Associate to submit to a plan of monitoring and reporting, as the Covered Entity determines necessary to maintain compliance with this Agreement; and, or

(iii) provide the Business Associate with a defined time period to cure the breach; or

(iv) terminate the Agreement in accordance with applicable state statutes.

c. Before exercising any of these options, the Covered Entity will provide written notice of preliminary determination to the Business Associate describing the violation and the action the Covered Entity intends to take.

15. RETURN OR DESTRUCTION OF PHI

Upon termination, cancellation, expiration or other conclusion of this Agreement, the Business Associate will:

a. Return to the Covered Entity or, if return is not feasible, destroy all PHI and any compilation of PHI in any media or form. The Business Associate agrees to ensure that this provision also applies to PHI in possession of subcontractors or agents of the Business Associate provided to the agent or subcontractor by the Business Associate. The Business Associate agrees that any original record or copy of PHI in any media is included in this provision as are any original or copy of PHI provided to subcontractors or agents of the Business Associate by the Business Associate. The Business Associate agrees to complete the return or destruction as promptly as possible, but not more than [**Insert Number of Days]** business days after the effective date of termination of this Agreement. The Business Associate will provide written documentation evidencing that return or destruction of all PHI has been completed.

b. If the Business Associate believes that the return or destruction of PHI is not feasible, the Business Associate shall provide written notification of the conditions that make return or destruction infeasible. Upon mutual agreement of

the Business Associate and Covered Entity that return or destruction is not feasible, The Business Associate shall extend the protections of this Agreement to PHI and prohibit further uses or disclosures of the PHI of the Covered Entity without express written authorization of the Covered Entity. Subsequent use or disclosure of any PHI subject to this provision will be limited to the use or disclosure that makes return or destruction unfeasible.

16. MISCELLANEOUS

a. Automatic Amendment: This Agreement shall automatically incorporate any change or modification to HIPAA as of the effective date of the change or modification. The Business Associate agrees to maintain compliance with all changes or modifications to HIPAA as required.

b. Interpretation of Terms or Conditions of Agreement: Any ambiguity in this Agreement shall be construed and resolved in favor of a meaning that permits the Covered Entity and Business Associate to comply with HIPAA.

c. Submission of Compliance Plan: The Business Associate agrees that a HIPAA compliance plan may be requested by the Covered Entity. If requested by the Covered Entity, the Business Associate agrees to provide periodic reports of the progress of the compliance plan. Further, the Business Associate agrees that the plan and progress reports will comply with the requirements of the Covered Entity.

IN WITNESS WHEREOF, the undersigned have caused this Agreement to be duly executed by their respective representatives.

COVERED ENTITY	**BUSINESS ASSOCIATE**
By: _____	**By:** _____
Title: _____	**Title:** _____
Date: _____	**Date:** _____

APPENDIX: 27

PROTOCOLS FOR EXTERNAL QUALITY REVIEW OF MEDICAID MANAGED CARE ORGANIZATIONS

WISCONSIN MEDICAID

APPENDIX 27

PROTOCOLS FOR EXTERNAL QUALITY REVIEW OF MEDICAID MANAGED CARE ORGANIZATIONS

http://www.cms.hhs.gov/medicaid/managedcare/mceqrhmp.asp

The Balanced Budget Act of 1997 (BBA) directed the Department of Health and Human Services to develop protocols to be used to fulfill the statutory requirement that State Medicaid agencies annually provide for an external, independent review of the quality outcomes and timeliness of, and access to, services provided by Medicaid managed care organizations (MCOs).

In response to the BBA requirement, nine protocols and one appendix were developed. Of these nine protocols, DHHS' final rule on External Quality Review (EQR) of Medicaid Managed Care Organizations published on January 24, 2003 requires only the first three to be used by state Medicaid agencies.

The final rule also states that EQR activities are to be conducted in a manner consistent with (as opposed to identical to) the protocols. This approach will ensure that the protocols do not prevent states and their EQR Contractors from using more refined approaches to these activities as they develop.

The remaining six protocols are offered for use at the option of a state whenever a state wants information from these activities to be used as a component of external quality review and enhanced Federal Financial Participation in the costs of these activities.

PROTOCOL ONE - MANDATORY

http://www.cms.hhs.gov/medicaid/managedcare/protobba.pdf

The first protocol is to be used to determine MCO compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. This protocol requires the use of two main sources of information to determine compliance with proposed BBA requirements: 1) document review and 2) interviews with the MCO personnel. This combination will lead to a better understanding of organization performance.

Information contained in the first protocol includes a description of how to efficiently combine and conduct document review and interview activities in order to determine the extent to which an MCO complies with the BBA regulatory provisions. This protocol also includes the following three attachments:

- A summary of compliance determination activities of public and private quality oversight organizations (Attachment A).
- A description of compliance determination activities for individual regulatory provisions (Attachment B).
- A sample documentation and reporting tool (Attachment C).

PROTOCOL TWO - MANDATORY
http://www.cms.hhs.gov/medicaid/managedcare/protopmv.pdf

The second protocol specifies two types of activities to be undertaken by an external review organization (EQRO) to validate performance measures. The first types of activities are done to evaluate the accuracy of Medicaid performance measures reported by or on behalf of an MCO. The second type of activity is done to determine the extent to which Medicaid-specific performance measures (calculated by or on the behalf of an MCO) follow specifications established by the State Medicaid agency (the State) for the calculation of the performance measure(s). Review work sheets, validation tools, guide for interviews, assessment questions, identifying the documents and processes for review, and an example of a completed performance measure validation worksheet are included as attachments to this protocol.

Activities described by the protocol address:
- A review of the data management process of the MCO
- An evaluation of algorithmic compliance (the translation of captured data into actual statistics) with specification defined by the State
- Verification of either the entire set or a sample of the State-specified performance measures to confirm that the reported result are based on accurate source of information.

PROTOCOL THREE – OPTIONAL
http://www.cms.hhs.gov/medicaid/managedcare/protopmc.pdf

The third protocol specifies activities to be undertaken by an EQRO to calculate performance measures. EQROs are to calculate measures of MCOs performance in accordance with specifications prescribed by the State Medicaid agency. In addition EQROs are to provide information to the State on the extent to which the MCOs information system (IS) provided accurate and complete information necessary6 for the calculation of performance measures. Worksheets, interview guide, and an identification of documents for potential review are included as attachments to this protocol.

Protocol activities include:
- Determining the extent to which the MCO's is capable of collecting and integrating data from all components of its network, in order to enable valid measurement of its performance on dimensions of care specified by the State.
- Validly measuring MCO performance on the dimensions specified by the State through adherence to technical specifications defined by the State.
- Timely reporting to the State the specified performance measures in the format defined by the State.
- Reporting the findings of the EQRO activities in a manner that facilitates understanding of the MCO's performance against any State-established minimum levels for performance.

PROTOCOL FOUR - OPTIONAL
http://www.cms.hhs.gov/medicaid/managedcare/protopmc.pdf

The fourth protocol specifies activities to be undertaken by an EQRO for validating encounter data. This protocol is based almost entirely on the guide for states developed by MEDSTAT for

validation of encounter data. Examples of data quality standards, a table of benchmark utilization rates, and a sample medical record review findings tool are included as attachments to this protocol.

The protocol consists of five sequential activities:

- Review of State requirements for collection and submission of encounter data.
- Review of each MCO's capability to produce accurate and complete encounter data
- Analysis of MCO electronic encounter data for accuracy and completeness
- Review of medical records, as appropriate, for additional confirmation of findings,
- Submission of findings

PROTOCOL FIVE - MANDATORY
http://www.cms.hhs.gov/medicaid/managedcare/protopipv.pdf

The fifth protocol specifies activities to be undertaken by an EQRO for validating performance improvement projects (PIPs) undertaken by an MCO. This protocol relies heavily on a guidebook produced by the National Committee for Quality Assurance (NCQA) "*Health Care Quality Improvement Studies in Managed Care Settings: A Guide for State Medicaid Agencies*." Origins of the protocol, and a performance improvement evaluation worksheet are included as attachments to this protocol.

This protocol describes three activities that are undertaken in validating PIPs.

- A ten step process for assessing the MCO's methodology for conducting the PIP along with questions that can be used to evaluate each of the ten processes.
- A methodology for verifying actual PIP study findings (optional).
- A summary that evaluates the overall validity and reliability of the PIP results.

PROTOCOL SIX - OPTIONAL
http://www.cms.hhs.gov/medicaid/managedcare/protopipc.pdf

A state may require an EQRO to conduct a PIP in addition to those PIPs an MCO is required to undertake on its own. The sixth protocol specifies ten steps for an EQRO to take when conducting a PIP for a Medicaid MCO. This protocol relies heavily upon the guidebook referred to in protocol five (see above). Origins of the protocol and a sample worksheet for conducting performance improvement projects are included as attachments to this protocol.

The ten steps to be taken by an EQRO when conducting a PIP include:

- Select the study topic(s).
- Define the study question(s).
- Select the study indicator(s).
- Use a representative and generalizable study population
- Use sound sampling techniques (if sampling is used).
- Reliably collect data.
- Implement intervention and improvement strategies
- Analyze data and interpret study results
- Plan for "real" improvement.

- Achieve sustained improvement

PROTOCOL SEVEN – OPTIONAL
http://www.cms.hhs.gov/medicaid/managedcare/protofs.pdf

On occasion, a state may elect to conduct a study on a one-time basis without follow-up. The seventh protocol specifies seven steps for EQROs to use in conducting focused studies of clinical and nonclinical health care services provided by Medicaid MCOs at a point in time as directed by the State Medicaid agency. This protocol also relies upon the guidebook referred to in protocol five. A worksheet for conducting a focused health care study and origins of protocol seven are included in attachments to this protocol.

Seven steps to be undertaken when conducting a focused study include:
- Select the study topic(s).
- Define the study questions(s).
- Select the study indicatory(s).
- Use a representative and generalizable study population.
- Use sound sampling techniques (if sampling is used).
- Reliably collect data.
- Analyze data and interpret study results.

PROTOCOL EIGHT – OPTIONAL
http://www.cms.hhs.gov/medicaid/managedcare/protosrvy.pdf

The eighth protocol describes activities that must be undertaken in administering surveys if those surveys are to be included as a component of the external, independent quality review required under federal law for Medicaid MCOs. References/works consulted in the development of this protocol and a survey planning and implementation documentation worksheet are included as attachments to this protocol.

The activities that must be undertaken as part of a methodologically sound survey include:
- Identification of a survey purpose(s) and objectives(s).
- Identification of intended survey audience(s).
- Selection of the survey instrument.
- Development of the sampling plan
- Development of the strategy for maximizing the response rate
- Implementation of the survey
- Preparation and analysis of the data obtained from the survey
- Documentation of the survey process and results

PROTOCOL NINE – OPTIONAL
http://www.cms.hhs.gov/medicaid/managedcare/protosrvy.pdf

This protocol specifies seven activities that must be undertaken to validate a survey if the survey is to be included as a part of the external independent quality review required under federal law for Medicaid MCOs. This protocol can be used to validate all types of surveys.

References/works consulted in the development of this protocol and a survey validation worksheet are included as attachments to this protocol.

These activities include:

- Review survey purpose(s) and objective(s).
- Review intended survey audience(s)
- Assess the reliability and validity of the survey instrument
- Assess the sampling plan
- Assess the adequacy of the response rate
- Review survey data analysis and findings/conclusions.
- Document evaluation of survey.

APPENDIX Z
http://www.cms.hhs.gov/medicaid/managedcare/protoappz.pdf

This appendix contains a description of activities for assessing an MCO's information system. An Information System Capabilities Assessment (ISCA) form, an ISCA reviewer-worksheet and interviewer guide, an example of a flow chart describing performance measure data of information system structure, and an example of a data vendor integration spreadsheet are included in this appendix.

An assessment of the MCO's information system is a process of four consecutive activities which includes the following:

- The MCO completes the information systems capabilities assessment (ISCA).
- An EQRO review of the completed ISCA and accompanying documents.
- An EQRO Follow-up interviews with MCO staff.
- The Analysis of information obtained through ISCA and follow-up interviews.

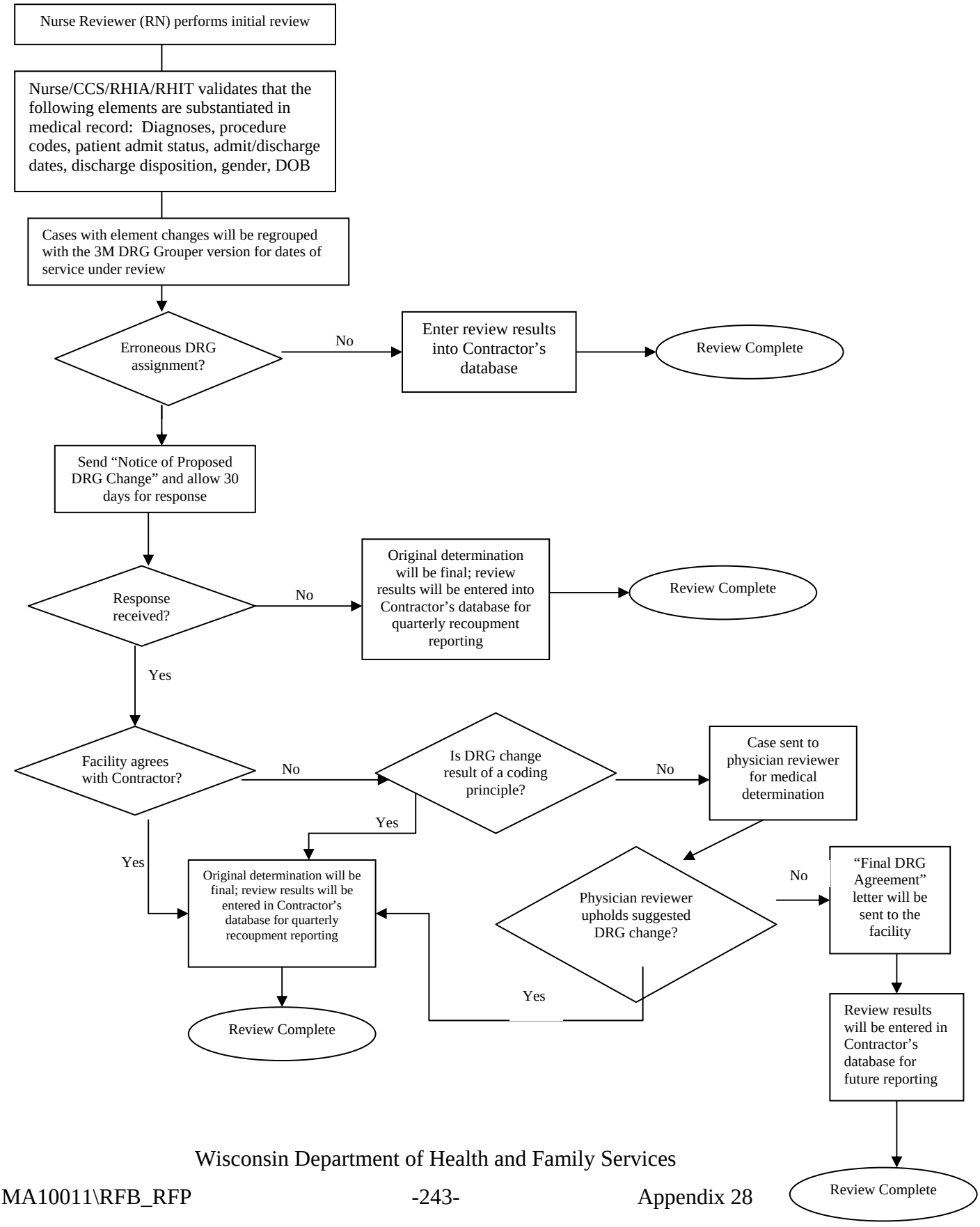
APPENDIX: 28

DIAGNOSTIC RELATED GROUP
DATA VALIDATION FLOW SHEET

WISCONSIN MEDICAID

APPENDIX 28

CONTRACTOR MEDICAID DRG/DATA VALIDATION REVIEW



APPENDIX: 29

PHYSICIAN/EXPERT CONSULTATION INFORMATION

WISCONSIN MEDICAID

APPENDIX 29

PHYSICIAN AND/OR EXPERT CONSULTATION

Consultants must be professionals who have an established expertise in their areas and are currently in practice. The Contractor will provide administrative support staff able to research the literature and quickly summarize findings in a concisely written manner. The Contractor is responsible for providing practicing physicians and experts to exchange pertinent information either by writing, e-mail, conference call or face-to-face consultation. The number of consultations needed is likely to range between zero to five times per month.

Topics include but are not limited to:

- New devices
- Experimental procedures
- Drugs
- New technology
- Novel uses of equipment
- Other clinical areas

Response of the Consulting Physician(s)/Expert(s):

- Can range from a simple telephone consultation to an extensive literature search.
- Must reflect current practice, state of the art, and standards of care if they have been established.
- Must be defensible and consistent with current literature.
- Contractor will provide administrative support at hearing(s) as requested.
- Must always include a written component so that if a response is provided by telephone, a written record is maintained by the EQRO and sent to the person requesting the consultation. The written response can be as simple as an e-mail follow-up to a telephone conversation or as detailed as a formal report summarizing a literature search.
- Must be completed and submitted to DHCF within fifteen (15) working days from the date the physician(s) and/or expert(s) begin the review process.
- At the discretion of the DHCF a verbal response may be required within two (2) working day from the date the review process begins.

In addition the EQRO will also provide:

- Administrative support for this panel including any materials needed by the physicians/experts.
- A year-end summary of consultations and an annual meeting with the EQRO contract manager to evaluate the process.